



State Title V Block Grant Narrative

The following PDF was created from the most up-to-date electronic files available from the State for its Title V Maternal and Child Health Services Block Grant 1999 annual report and 2001 application. Some changes in fonts, formatting, page numbers, and image quality may have occurred during the conversion of the document to a PDF.

Sections 5.4 – 5.7, containing standard forms and detailed descriptions of national and State performance and outcome measures, are not included in this PDF. Data from these sections can be viewed in interactive formats on the Title V Information System Web site (<http://www.mchdata.net>).

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1.4 Overview of the State

The Office of Maternal and Child Health (OMCH) operates in partnership with the federal government and the State's medical community, including private practicing physicians, county health departments, community health centers and hospitals. Categorical programs to address specific needs for targeted groups are limited with 80 percent of the Office's energy being used to develop systems for the provision of both population-based and target specific preventive interventions as well as infrastructure for the support of the maternal and child health populations.

Availability of services for West Virginia's MCH population has increased dramatically, however, there remain areas of the State that simply lack medical practitioners. In addition, meeting the needs of chronic or disabled populations is impaired by the lack of medical sub-specialty providers, such as occupational therapists, physical therapists, speech pathologists, dentists; and as is typical with most states, pediatric sub-specialties are mostly available at tertiary care sites. To attend to these problems, the Bureau for Public Health, in collaboration with the West Virginia University School of Medicine, sponsors a rural practice rotation for physicians, social workers, and other service providers, with the intent of encouraging the establishment of rural practices, as well as expanding immediate service capability, since these practitioners render hands-on care. The Office of Maternal and Child Health further addresses the medical sub-specialty shortage by providing loan repayment and educational stipends for recruitment and retention of occupational therapists, speech pathologists, and physical therapists. Further detail about the state and its people is referenced in the needs assessment, 3.1.2.

West Virginia House Bill 2388 established a mandate for the universal testing of newborns for hearing loss. The Newborn Hearing Screening Advisory, as established in statute, has made testing recommendations, developed screening protocols, and assisted the Office of Maternal and Child Health with the development of user friendly education materials for inclusion in hospital birth packets and distribution through the Right From The Start Project. The passage of the West Virginia Birth Score, in this same legislation, further strengthens the State's ability to universally screen all newborns for developmental delay, hearing loss, and conditions that may place infants at risk in the first year of life. The original birth score instrument has been modified to accommodate hearing screening, so one instrument and one tracking system addresses the mandate. All WV birthing facilities began universal screening effective July 1, 2000. The MCH Provider Education unit (nurses) visited birthing facilities to offer technical assistance related to operationalizing the initiative.

1.5

The Office of Maternal and Child Health has historically purchased and/or arranged for health services to low income persons, including those who have health care financed under Title XIX. The Medicaid expansion of the 1980's resulted in health financing improvements, but it was Title V energy that developed obstetrical risk scoring instruments, recruited physicians to serve moms and children, including those with special health care needs. It was also Title V that established standards of care, and developed formalized mechanisms for on-site quality assurance reviews.

We have expanded income eligibility coverage for pregnant women to 185% of the FPL, using Title V monies. This was done in response to patient demand. Although the OMCH is less and less involved as a health care financier, we do continue to provide gap filling services when indicated.

At this point, SSI populations have not been enrolled in Medicaid Managed Care (MMC), and we continue to present the case that this population requires services that do not fit well within the traditional medical model. In regards to other programs, we continue to recruit providers and provide training relative to EPSDT, including training for HMO providers. We also have maintained our existing network of outreach workers to encourage families to access primary preventive care, now offered by the HMO's.

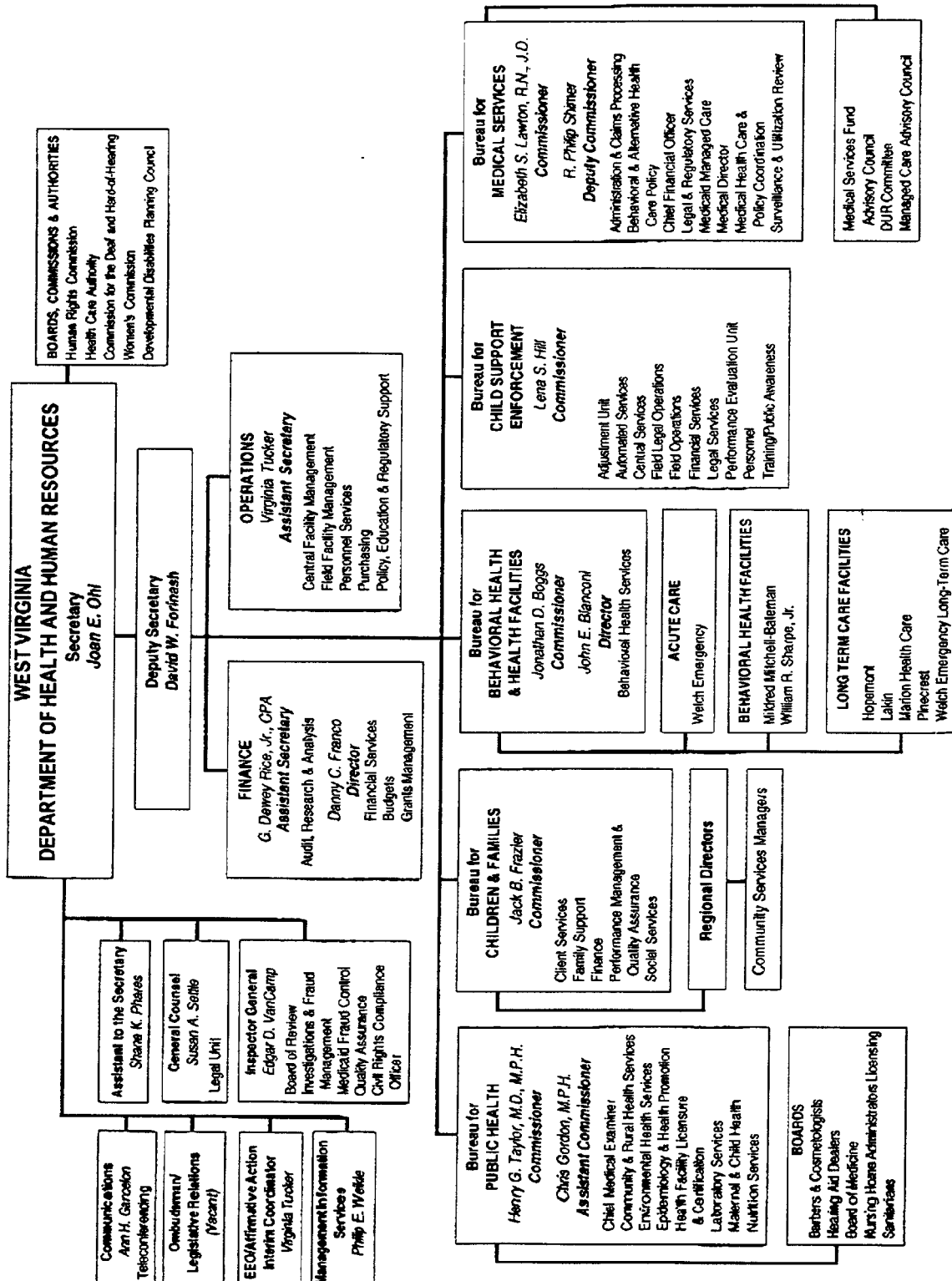
1.5.1 State Agency Capacity

1.5.1.1 Organizational Structure

West Virginia's Office of Maternal and Child Health is located within the State's Bureau for Public Health, administered by the umbrella organization, the Department of Health and Human Resources. The Bureau's overall goal is to attain and maintain a healthier West Virginia.

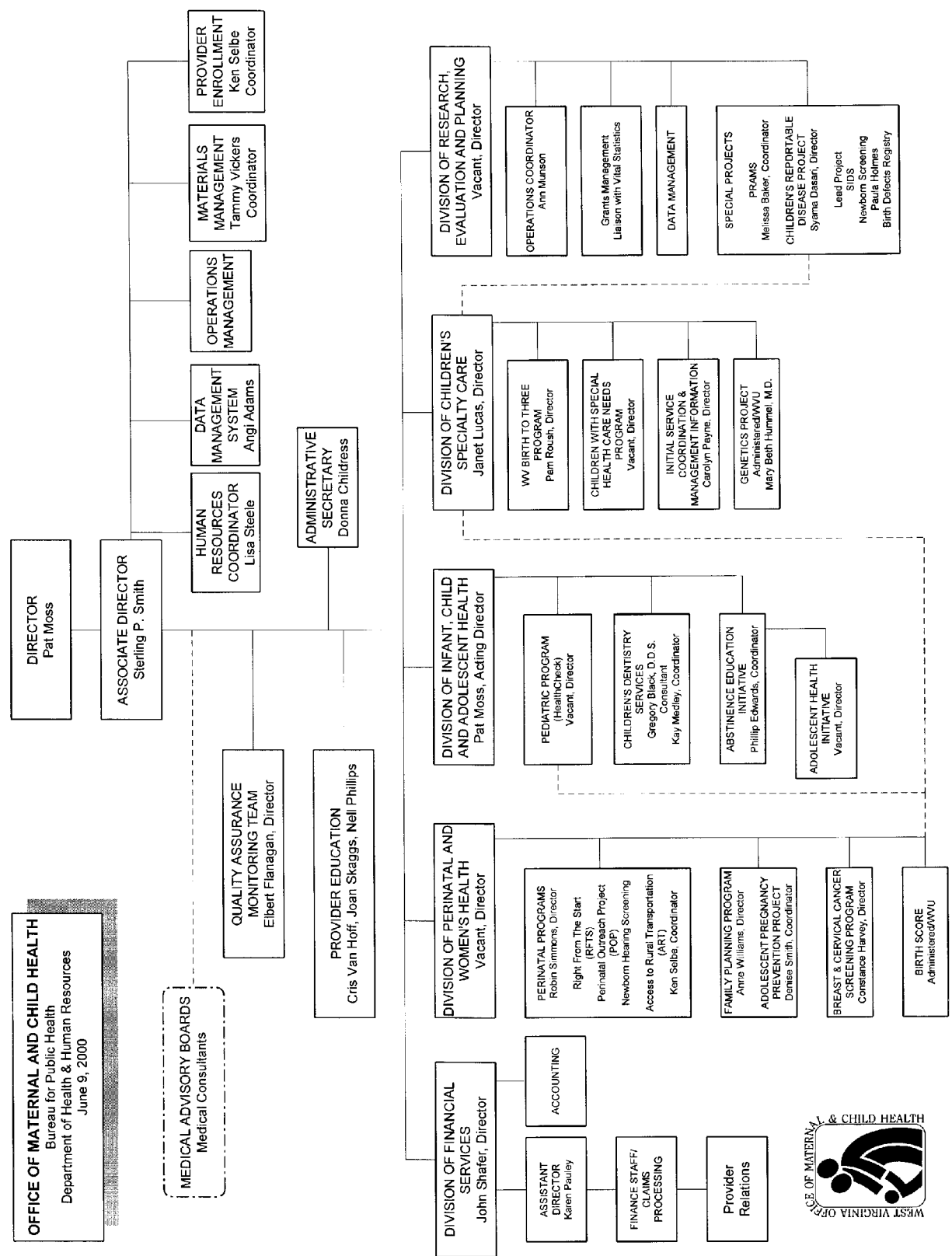
The Office of Maternal and Child Health provides operational guidance and support to providers throughout West Virginia to improve the health of families. In addition to providing funding support for actual service delivery, the Office of Maternal and Child Health funds projects intended to develop new knowledge that will ultimately improve the service delivery of the health community.

The Office of Maternal and Child Health is comprised of multiple divisions, programs, and projects all designed to promote improved health including access and increased utilization of preventive care. The Office of Maternal and Child Health's organizational structure includes the Division of Perinatal and Women's Health; Division of Infant, Child and Adolescent Health; Division of Children's Specialty Care; Division of Research, Evaluation and Planning; and the Division of Financial Services (see Office of Maternal and Child Health organizational chart on the following page).



Revised 4/20/00 og

OFFICE OF MATERNAL AND CHILD HEALTH
Bureau for Public Health
Department of Health & Human Resources
June 9, 2000



1.5.1.2 Program Capacity

As noted, the Office of Maternal and Child Health in West Virginia is constituted of five divisions, a Quality Assurance/Monitoring Team, Provider Education, Provider Recruitment, and an Administrative Unit (made-up of the Office Director, Associate Office Director and Human Resources Coordinator). With the exception of the Division of Children's Specialty Care, the Office of Maternal and Child Health does not deliver direct services but rather designs, oversees and evaluates preventive and primary service systems for West Virginia women and men of reproductive age, infants, adolescents, children and children with special health care needs. In FY 2000, MCH was also assigned responsibility for developing dental/vision care for adults transitioning from Welfare to work.

Division of Perinatal and Women's Health

The focus of the Perinatal and Women's Health Division of the Office of Maternal and Child Health is to promote and develop systems which address comprehensive services for women across the ages and infants in the first year of life. Administrative oversight includes perinatal care and education paid for by Title V and designed to improve quality of care provided by the medical community and hospitals, called Perinatal Outreach; birth scoring to identify children at high risk (including those with hearing loss); family planning; breast and cervical cancer screening services; and a rural transportation project to facilitate greater access to needed health care services. Additionally, these programs provide linkage and referral to other women's, infant's, and children's programs. The goal of these programs is to provide accessible care to women and infants up to one year of age, to reduce the current infant mortality rate in West Virginia and to improve the health of women of all ages.

The Right From The Start Project's eight Regional Lead Agencies and over 230 Designated Care Coordinators are charged with the responsibility of providing individualized case management, and facilitating access to care. These community partnerships facilitate access to services that are community-based and offered by persons who live and work within their geographical area of assignment.

Perinatal and Women's Health programs include Family Planning; Right From The Start; Perinatal and Special Projects, including Access to Rural Transportation; and Breast and Cervical Cancer Screening. In addition, this unit administratively oversees the Birth Score Project, which is housed in the Department of Pediatrics, West Virginia University's School of Medicine, and Perinatal Outreach Projects which are located in each of the states three tertiary care facilities. A brief description of each program/project follows:

Family Planning Program: The Family Planning Program arranges and financially supports comprehensive reproductive health care for low-income women, men, and adolescents through community-based provider arrangements. The Family Planning Program provides reproductive health services, including complete gynecological and breast examinations, cervical cancer screening, diagnosis and treatment of sexually transmitted diseases (STD), contraceptive supplies, pregnancy testing, and referral for identified medical problems. Health education and counseling is available for reproductive anatomy and physiology,

all contraceptive methods, and AIDS/HIV and STD prevention. The Program offers basic infertility services with interview, education, examination, appropriate laboratory testing, and referral, as needed. In addition, voluntary sterilization services are available to low-risk, uninsured male and female patients.

Family Planning medical services are offered statewide through a network of 128 clinic sites operating in all 55 counties of the State. These sites include 57 local health departments/satellite clinics, 58 primary care centers, 4 hospital outpatient centers, and 9 special agreement sites.

Women, men, and adolescents of reproductive age with income at or below 250 percent of the federal poverty level are eligible for Family Planning Program services. No patient below 100 percent of poverty may be charged for services provided as a result of Title X, Public Health Service funding, and Title XIX, Medicaid Program regulations. Local health departments and primary care centers maintain sliding fee schedules, based on annual poverty income guidelines and family size for those whose income is between 100 and 250 percent of the Federal Poverty Level. Providers are reimbursed according to the Program's medical visit rate, and with patient co-payment, when applicable.

For more than 20 years, OMCH has managed Family Planning, negotiating care arrangements and establishing clinical protocols for persons of childbearing age, including those with Title XIX coverage. MCH also monitors to assure services are delivered, as negotiated in contract, in accordance with national practice standards. The cost of the monitoring for Family Planning is provided by Title V, with the salary of one Monitor position offset 100% by the Title X funding source.

Referrals from the Family Planning Program for all patients to other appropriate medical service providers are expected for treatment and resolution of medical problems detected during the family planning examination that exceed the scope of the Family Planning Program. In particular, family planning patients with abnormal pap smears or clinical breast examinations are referred directly to the Breast and Cervical Cancer Screening Program, administered by OMCH, for further diagnosis through colposcopy, biopsy, or mammography. Formal and informal linkages between medical providers are imperative in the more rural areas of West Virginia where health care manpower and resources are limited.

Free pregnancy testing and options counseling are available at all family planning sites. With verification of pregnancy, the Office of Maternal and Child Health ensures the patient has located a prenatal care provider, and (if medically indigent) has been provided a shortened Medicaid application and an agency referral to WIC. Patients testing negative for pregnancy, who do not wish to be pregnant, are scheduled for comprehensive family planning services. This referral system is to ensure all pregnant women access the services and that low income, non-insured pregnant women receive care under the sponsorship of Title V, if ineligible for Medicaid.

Medical services, contraceptive and clinical supplies, laboratory services and educational materials are purchased, in part, with MCH Block funds. Annually, the Family Planning Program provides reproductive health services to approximately 62,000 women, men and adolescents in the State. In Fiscal Year 1999, 18,313 teens received Family Planning Program services. All family planning participants are screened for STD's, and the State STD Program, administered through Division of Surveillance and Disease Control, uses the Family Planning Program as the vehicle for early screening of sexually active persons.

In early 1999, the OMCH administration realized that a targeted focus on adolescent pregnancy prevention remained a critical need in West Virginia. Subsequently, administrative responsibility for adolescent pregnancy prevention was returned to the Family Planning Program.

The Adolescent Pregnancy Prevention Initiative, administered as a special focus of the Family Planning Program, provides development, oversight, and coordination of adolescent pregnancy prevention activities within the OMCH. Priority objectives include:

1. To develop and maintain a network of individuals involved in federal, state, local, public, and private initiatives which impact the issues of adolescent pregnancy prevention, sexuality, and reproduction; decision-making and risk reduction;
2. To address issues on a statewide level which impact access to or quality of adolescent pregnancy prevention services;
3. To create and maintain an annual profile of adolescent pregnancy in West Virginia, which includes the status of reproductive health and health risk indicators; health access and service delivery issues; utilization of Family Planning Program services and other related data;
4. To develop and conduct community education and outreach activities to promote public awareness of adolescent pregnancy prevention and related issues.

The Family Planning Program has designed a system which offers contraceptive care and education to prevent unintended pregnancies and to prevent the transmission of sexually transmitted diseases. Enabling sexually active individuals of all ages to make choices regarding the spacing and number of their children, and increasing the interval between births, family planning is an integral part of the efforts of the Office of Maternal and Child Health to reduce infant mortality and morbidity and to improve the health of West Virginia residents as a whole.

Breast and Cervical Cancer Screening Program: The Breast and Cervical Cancer Screening Program (BCCSP) was implemented in 1991 through a grant from the Centers for Disease Control. This program provides linkage to the Title V funded programs for eligible women by referring to Family Planning and other Bureau for Public Health projects.

The purpose of the BCCSP is to increase the number of West Virginia women who routinely receive screening for breast and cervical cancer. This comprehensive program targets women who are low income, specifically at or below 200 percent of the Federal Poverty Level, and are uninsured or underinsured. For the

Screening for breast and cervical cancer is provided through contractual agreements with 153 county health departments, primary care centers, hospital outpatient clinics and free clinics in the State's 55 counties. There are 72 mammography providers, 88 colposcopy providers and 34 providers of fine needle aspirations throughout the State. Services provided include a pelvic examination, a Pap smear, a clinical breast examination, patient education and a referral for a mammogram for women who are age eligible. Follow-up referrals for diagnostic services and treatment are also provided by the screening clinics, with limited treatment coverage provided to medically indigent women using State appropriated funds. Since its inception, the Program has screened 52,547 women for breast cancer and 57,472 women for cervical cancer.

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Right From The Start Project: The Right From The Start Project (RFTS) provides comprehensive perinatal services to low income women and infants up to one year of age. The Project provides the following services:

- Recruitment of medical practitioners to service low income, government sponsored populations (Title XIX, Title V).
 - Establish the expectation that national standards of care (ACOG) will be followed.
 - Recruitment and credentialing of practitioners to care for Medicaid and Title V sponsored obstetrical patients, including the completion of signed contractual agreements that establish expectation for care in accordance with national standards.
 - All participating providers complete signed agreements with OMCH specific to services/benefits, risk scoring, patient information exchanges.
- Direct financial assistance for obstetrical care for pregnant adolescents under the age of 18 who are *not eligible* for Medicaid.
- Direct financial assistance for prenatal care for *non-citizens*. (They may be eligible for Medicaid at the time of delivery as this is considered an emergency situation.)
- Direct financial assistance for obstetrical care for pregnant women *denied Medicaid*, but whose income is equal to or less than \$100 per month over 185 percent of the Federal Poverty Level.
- Limited coverage for prenatal patients who at the time of first prenatal visit have not received a Medicaid card and are subsequently denied, or prenatal patients whose Medicaid coverage is not backdated to cover the first visit. The services may include lab work, the initial prenatal visit, and ultrasound, if necessary. This was the closest we could come to presumptive eligibility. The cost of these services are paid for by MCH using Title V funds.
- Assistance for patient access to health care and the WIC Program.
- Coordination of medical care for Title V and Title XIX obstetrical patients and their infants/children less than one year of age. Coordination components include assessment care plan development, service referrals, follow-up and monitoring. All pregnant Medicaid and Title V cardholders are eligible for educational activities designed to improve their health (i.e., childbirth education, smoking cessation, parenting, nutrition).
- The Access to Rural Transportation (ART) Project, in conjunction with the Office of Family Support, Non-Emergency Medical Transportation Program, administers a statewide system to provide transportation dollars to needy infants and pregnant women prior to the actual

medical encounter to ensure access to “medically necessary” care. **The ART Project purchased approximately 13,374 transportation services in 1998.**

- Establishment and support for an Advisory Council comprised of current practicing OB/Gyn's to provide medical expertise and operational guidance.

Preventive and primary care services to RFTS infants are provided in accordance with EPSDT Program guidelines, and all RFTS infants are eligible for care coordination their first year of life. The State's neonatal intensive care units, the Birth Score Program, and the medical community identify and assist in identification and referral of high risk infants to RFTS care coordination.



Perinatal Outreach Project: Perinatal education efforts has its origins in the Improved Pregnancy Outcome Projects of the 1970's. The method used for skill enhancement has changed, but the opportunity and need to link tertiary care expertise to community providers remain constant. Areas of assignment for each facility are portrayed in the Needs Assessment.

Division of Infant, Child and Adolescent Health

Abstinence Only Education: The West Virginia Partnership for Abstinence Only Education was established in 1997 with federal funding provided under Title V. This Project is housed in the Division of Infant, Child, and Adolescent Health, and the Project's primary goal is to establish community partnerships that support educational opportunities at the local level, designed to increase youth decision-making, discourage use of alcohol and drugs, and the early onset of sexual activity. At this time, abstinence only education efforts are available in all of West Virginia's fifty-five counties. Preventive services for youth is a priority in West Virginia. Our adolescents and their families are community-based, organized training opportunities provided by a workforce hired from the community they serve. This workforce, called Adolescent Health Coordinators, are located in each region of the state, see Needs Assessment, Site Location map, page 134. These Coordinators offer young people, parents, and other significant adults in a child's life

skill building on conflict resolution, communication, increased awareness of harmful consequences of substance use, and strategies to develop self-reliance and improved decision making. All the above fit within the context of building stronger more resilient youth, living in healthy homes and communities, and fits well within the federal abstinence tenets. See Adolescent Health Initiative for further detail.

Pediatric Program: The West Virginia Bureau for Public Health, Office of Maternal and Child Health administers the West Virginia EPSDT Program, WV HealthCheck **T**, under contract with the Bureau for Medical Services, which is also housed within the Department of Health and Human Resources.

The EPSDT Program has an extensive outreach component responsible for meeting federal EPSDT informing, linking and follow-up requirements. Pediatric Program Specialists and Family Outreach Workers (FOW) are assigned to each region and county to accomplish these tasks. FOW's are paraprofessionals, hired and housed in the community in which they live and work. Home visitors, FOW's, reach many difficult to access families because they go to them. The home visit signals willingness to reach out to the family, with us making accommodations rather than asking "them" to visit the agency. The latest data, submitted to HCFA, indicates the EPSDT utilization rate in West Virginia is at 53.7% of all eligibles participating in screening, while the national penetration rate is 37%. **This rate is a significant decline from the previous year, precipitated in part by a more than 25% increase in the number of children eligible for Medicaid and the abrupt closure of one health maintenance organization.** In 1999, approximately 50,000 home visits were performed by Family Outreach Workers across the State.

Family Outreach Workers make contact with the families of all newly eligible Medicaid children to inform them about EPSDT and to assist them with referral and transportation. This contact is initiated by letter and/or home visit, affording a face-to-face discussion of the value of preventive care while offering staff the opportunity to link families with other needed services such as WIC, Head Start, and the local food and clothing pantry. This same staff distributes monthly schedules of children with a health visit due and provides follow-up on missed appointments and referrals. The FOW's routinely do face-to-face contact, in the form of a home visit for persons who have missed one or more appointments. The follow-up for patients not keeping regularly scheduled appointments is viewed positively by the medical community, who frequently request this service.

Program Specialists recruit, orient and provide ongoing technical assistance to EPSDT providers and have been especially active in recruiting additional providers for underserved areas. These activities have been helpful in establishing the desired eligible child to provider ratio; however, the influx of CHIP eligibles has presented an additional challenge since the WV medical community is presently at capacity. The Program provides ongoing staff development to enhance skills needed to better market the EPSDT Program to both providers and families. Program Specialists, who recruit, train, and provide technical assistance to participating medical providers, have also been active in working with local school systems to increase the number of school based clinics and on site EPSDT evaluations. **The number of students using school-based**

health centers has increased by 21% in the third quarter of 1999-2000. The Pediatric Program has been successful in increasing the overall number of EPSDT providers over the past several years and routinely provides EPSDT orientation for HMO providers serving Medicaid enrolled children.

Semi-annual meetings are held for the Pediatric team to include skill building components geared toward building home visiting and marketing skills as well as data entry and utilization of computer technology.

The *Adolescent Health Initiative* is a special program, financed solely by Title V, that addresses the most prevalent health risk facing adolescents today by empowering communities and supporting efforts that build resiliency and strengthen families.

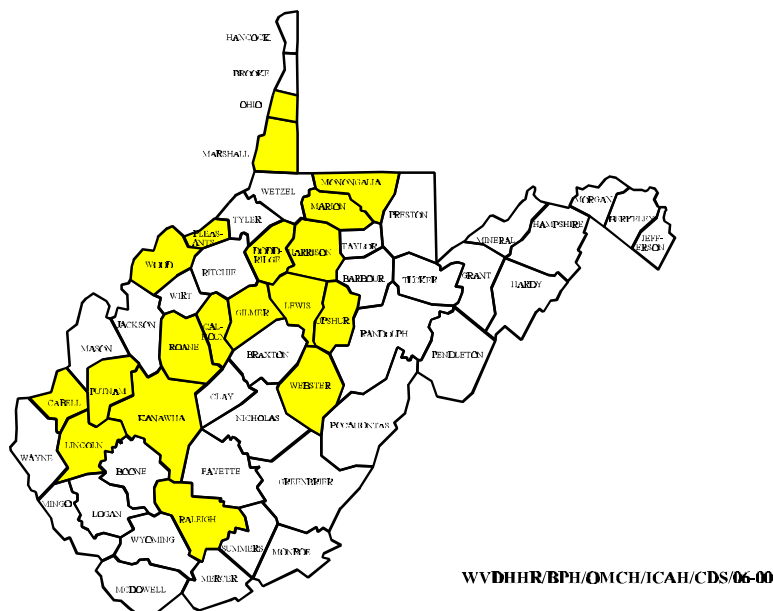
- Regional Adolescent Health Coordinators work to improve utilization of preventive health services for youth 10-17 years by creating community/family awareness of this population's health needs.
- Community support and coalition building facilitates the local development of services to meet the unique needs of this population while respecting community values.
- Educational programs emphasize preventive services and reduction of risk behaviors such as tobacco and alcohol/drug use, injury prevention.
- Adolescent Health Coordinators have developed, for community use, teaching modules that address dating-violence, decision-making, designed to increase resiliency among the State's youth.
- Coordinators offer community-based multi-service approaches to adolescents including workshops designed to promote child-family interaction and communications. One teaching module in frequent use is "Talking With Your 10 to 15 Year Old."
- Project efforts enhance the work of the abstinence only initiative by promoting individual asset building among youth, and offering parent-child communication workshops.

As stated previously, this program is closely linked with the State's Abstinence Education Initiative because of the similar mission.

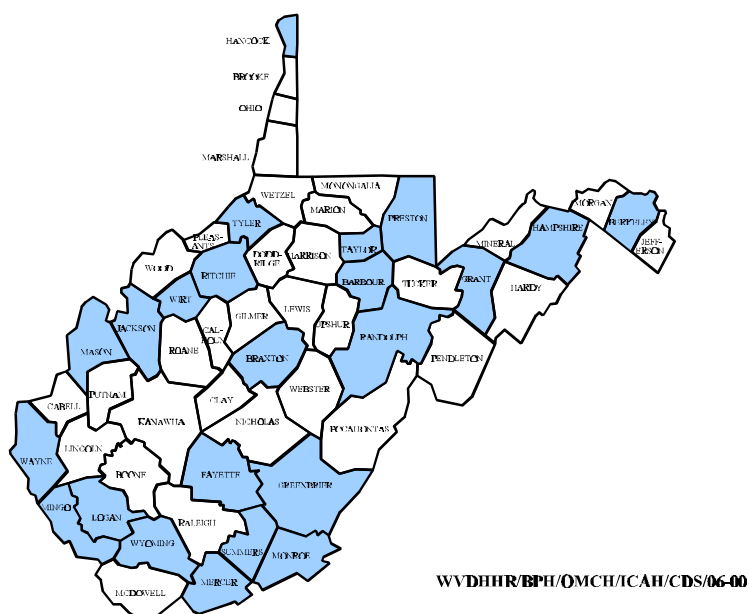
The *Children's Dentistry Program* works in concert with other Office of Maternal and Child Health Programs, Head Start and the public schools to promote awareness and availability of dental health services as an integral part of preventive, primary health services. Dental health efforts are funded from the Preventive Health Block Grant, Title V, and State appropriations. The program conducts needs assessments, provides fiscal resources to local communities to support learning opportunities for children which encourage behavioral change; i.e., regular check-ups, brushing/flossing, use of mouth guards during sports activities.

- The Program provides funds to support community-based public education relative to oral hygiene and mouth injury prevention.

- ### Counties Having No Need of Fluoridation



Counties with Moderate Fluoridation Need



A map of West Virginia showing its 50 counties. Fifteen counties are shaded in red, indicating a need for public water determined by population. The red-shaded counties are Hancock, Tucker, Putnam, Morgan, Boone, Lincoln, Logan, Wayne, Mingo, Cabell, Boone, Wayne, Lincoln, Logan, and Wayne. The remaining 35 counties are white.

- Fluoride drops and tablets are dispensed through local health departments, WIC offices and at child care sites by health care providers authorized to dispense fluoride, if the child does not have Medicaid or insurance coverage. Medicaid cardholders needing supplements are given prescriptions for local pharmacy use.
- Recruits and encourages licensed dentists and hygienists to provide direct program care for CHIP and Medicaid sponsored children.
- Provides and approves literature that addresses oral health needs for distribution. Literature and program operational guidance is distributed using the Pediatric Program Specialists who routinely visit the medical practitioners' offices, see reference earlier to field staff under EPSDT.
- Annually, prepares and distributes a listing of all WV dentists serving children, including those accepting Medicaid reimbursement. This list is distributed to all providers of primary care, school nurses, and other relevant personnel.
- The Children's Dentistry Program also provides literature to the Right From The Start's Regional and Designated Care Coordinators to address dental care for pregnant women and encouraging infant teeth care to reduce the incidence of baby bottle tooth decay.

The overarching goal of Children's Dentistry is to promote the value of oral health, build service capacity throughout the State by providing technical assistance to providers offering direct care; involve advanced education in developing strategies to address professional shortages; and improving access using CHIP and Medicaid as the health financing component. In years 2000 and 2001, fiscal resources will be provided local health departments to support, in part, the salary of staff involved in direct oral care for children. The money is to support the development of billing capacity, patient recruitment/retention, to enable the local health departments to establish a share of the marketplace.

Division of Research, Evaluation and Planning

This Division is responsible for the epidemiological and other research activities of the Office of Maternal and Child Health, including all programmatic data generation and program/project evaluation endeavors, as well as ensuring that the Office of Maternal and Child Health's planning efforts are data-driven. All of the Office of Maternal and Child Health's program specific data personnel are housed in this Division, and are linked with program leadership to assure consistent visioning.

The Division administers the Pregnancy Risk Assessment Monitoring System (PRAMS) Project and the Childhood Lead Poisoning Prevention Project (CLPPP), both sponsored by the Centers for Disease Control and Prevention (CDC); the Sudden Infant Death Syndrome (SIDS) Project mandated by State Statute but financed by Title V; and in conjunction with the Office of Laboratory Services, the Newborn Metabolic Screening Project. This unit handles all population-based data used to influence programs and services, including children with positive findings for hearing loss and the birth defect registry.

The Division maintains databases for the Children's Dentistry Program community needs assessment; Right From The Start Project; the Breast and Cervical Cancer Screening Program; and the West Virginia Birth to Three Program (Early Intervention/Part C - IDEA).

This Division also oversees the following:

Pregnancy Risk Assessment Monitoring System which surveys mothers who have recently given birth and asks questions related to the following topics:

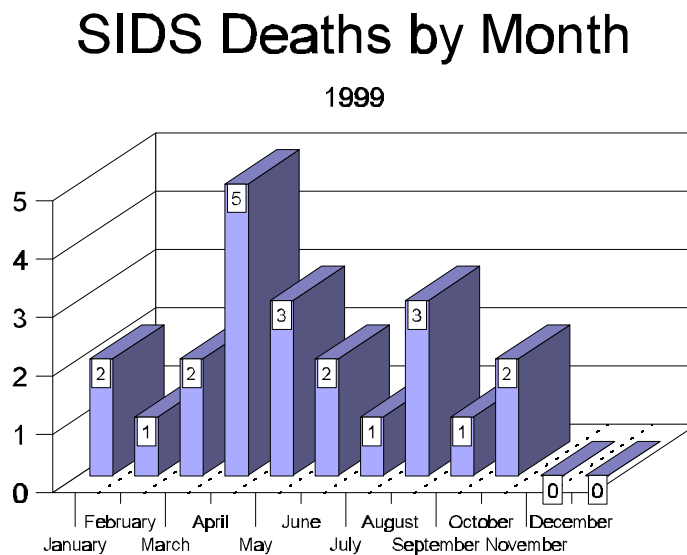
1. Prenatal Care
2. Barriers to Prenatal Care
3. Maternal Nutrition
4. Maternal Obstetric History
5. Maternal Use of Alcohol and Cigarettes
6. Maternal Stress
7. Pregnancy-Related Morbidity
8. Infant Status
9. Infant Health Care

10. Maternal Economic Status

The Survey is mailed to approximately 2,000 mothers per year from a sampling of low/normal birth weights, and maternal age <19 and >19 years of age. Data from this survey is used in planning for Office of Maternal and Child Health activities and to identify system gaps.

Children's Reportable Disease: This Project oversees the daily operation of the SIDS Project, the Newborn Metabolic Screening Program, Birth (Defect) Registry, and the Childhood Lead Poisoning Prevention Project. The data collection and research aspects of these projects are considerable and drives the programmatic activities which are connected with the Division of Children's Specialty Care, under the Systems Development Initiative (SSDI).

The ***Sudden Infant Death Syndrome Project*** collects and reports data regarding the occurrence of SIDS deaths in the State. An Advisory Committee, made up of medical personnel, clergy, mental health professionals, and parents provide ongoing direction for this Project. When a SIDS death is reported, a local health department nurse makes a home visit to interview and assess the needs of the parents. The visitor is expected to make referrals for grief/support counseling when requested. A master listing of the statewide community behavioral health center sites is made available as a referral resource. In 1999 there were 22 infant deaths attributed to SIDS. OMCH prepares a legislative activity report quarterly which portrays the number of SIDS deaths by county, and by sleeping position. A chart portraying incidence for 1999 is below:



The ***Newborn Metabolic Screening Project*** works with the Office of Laboratory Services to ensure that every newborn in the State is screened for PKU, Galactosemia and Hypothyroidism as well as hemoglobinopathies, if appropriate. Any necessary follow-up is provided by state office nursing personnel,

in collaboration with the child's primary care physician. Children with inborn errors of metabolism receive special consultation through the West Virginia University, Department of Pediatrics-Genetics Program, as part of a contractual agreement with OMCH. Title V state office nurses and administrative personnel track all medically prescribed food stuffs/formulas and have responsibility for assuring the timely "drop shipment" of formulas to families, in addition to coordination of care between the medical community and the family.

The ***Childhood Lead Poisoning Prevention Project*** is a collaborative effort in the Bureau for Public Health, Office of Maternal and Child Health, funded by the Centers for Disease Control and Prevention. An Advisory guides the operation of the Program, assisting the State with determining the extent of childhood lead poisoning in West Virginia. To this end, extensive data gathering and analysis are routinely distributed. The Office of Environmental Health Services, using its local network of community-based sanitarians, provide assessment of home and environment, for residences of children with elevated blood lead levels. Children with elevated blood lead levels are followed by local health staff, who visit their home, guiding the family through the process of care. Pediatric programs administered by MCH have routinely established the expectation for lead screening of the State's children, and Title V has paid for the screening and testing of the uninsured.

The ***Birth (Defect) Registry*** is a population-based surveillance system used to identify infants that might benefit from specialty care services administered by the Office of Maternal and Child Health. Special outreach efforts are extended to families of children identified in this fashion, using the Children's Specialty Care (CSC), Single Point of Entry, developed using the SSDI grant monies. The Project leader works closely with the Children's Specialty Care Division to assure families who have a child born with a birth defect receive a mailing which identifies the OMCH as a conduit for health care referral, information, and family support. **We do not reference that the child may have a special health care need.**

Division of Children's Specialty Care

This Division has been completely re-engineered to incorporate the Children with Special Health Care Needs Program, the West Virginia Birth to Three/Early Intervention Part C Program, and the SSDI Project for improved functioning.

The ***Children with Special Health Care Needs Program*** has a strong direct service component. The Program is structured to be community based and family-centered. Clinics have been established statewide to provide services as close to family residence as possible. In addition to contracted specialty physicians, clinics are also staffed by nurses, social workers and support staff who work as a multi-disciplinary team to provide health care management services and psycho-social support. These services include: authorization of Durable Medical Equipment; assistance with transportation, development of individualized care plans and assessments; arrangements for follow-up care, assistance with classroom service accommodations; assessment of daily living skills; and assistance with transitioning to adult living and workforce entry.

The Office of Maternal and Child Health continues to work diligently with the members of the SSI/OMCH Task Force to formalize outreach and agency linkages to achieve awareness/knowledge of who and how programs can be accessed. While this cooperative agreement encompasses all disabled children, our initial efforts in 1996 targeted low birthweight babies and early intervention children (birth to three years of age). More recently, the Task Force began efforts to ensure that children with disabilities who are within transitional age groups (specifically, three to six years and 16 to 21 years) receive prompt, appropriate services to enable a smooth transition to school and/or the workplace. The Task Force works toward these goals by providing a forum for regular discussion of policy and programs. Through these meetings, program implementation and changes are discussed to make sure that they are working in concert with one another. Overall, the Task Force seeks to ensure that children with or at risk for developing disabilities and their families benefit from an integrated, seamless system of services and supports that is family centered, community based, and culturally competent.

Through a cooperative agreement dating back more than twenty years between the Office of Maternal and Child Health and Bureau for Medical Services-Medicaid, Children with Special Health Care Needs staff provide case management services to Title XIX sponsored children, which maximizes Title V monies for non-insured, medically indigent children. Consistent fee schedules are applied to Children with Special Health Care Needs services regardless of payor source (Title V/Title XIX). In 1998-1999, the Individualized Child and Family Assessment form was revised and now includes levels of care as case management standards. Definitions utilized as developed by Case Management Society of America:

- Level 1:** Clinical - Patient sees one or two medical specialists for periodic/episodic medical care.
 Social - There are no major identified social service needs.
 Intensity of Contact - Contacts every six (6) months to reassess care needs.
- Level 2:** Clinical - Patient is seen by three or more medical specialists, requires four or more medical visits/interventions per year, or two unplanned hospitalizations per year. Patient has technology/equipment in place for 6 months or more, and parents feel comfortable in managing daily care.
 Social - Social service needs consist of information and referral, or transportation services, with periodic follow-up.
 Intensity of Contact - Contacts every three (3) months, or as specified in the Patient/Family Care Plan.
- Level 3:** Clinical - Patient has a newly diagnosed life threatening or life limiting condition, a condition requiring three or more medical visits/interventions per month, or has three or more hospitalizations per year. Patient has multiple

technology/equipment needs, requiring frequent parental/care giver teaching.

Social - Family/patient has multiple social service needs such as parenting skill needs, behavioral health problems, grief or loss issues, assistance with medical compliance, family violence, or possible abuse or neglect. Patient/families in evaluation status are at this level until treatment plan is complete.

Intensity of Contact - Monthly contacts, or as specified in the Patient/Family Care Plan.

A Care Plan Notebook was developed to incorporate medical records, patient information, referral numbers, and other pertinent information for the patient/family of Children with Special Health Care Needs and Birth to Three Program participants. The notebook was developed to support the family as the source of care coordination for their children with special needs.

West Virginia's *Birth to Three/Early Intervention Part C Program* entered in 2000, its seventh year of participation, in ensuring that all eligible infants/toddlers and their families receive a comprehensive array of early intervention services. Eligibility is for infants and toddlers up to age 3 with certain conditions and is not dependent on financial needs. Generally, a child is eligible for Early Intervention Part C services if they:

1. Are experiencing a developmental delay.
2. Have a diagnosed physical or mental condition which has a high probability of resulting in developmental delay – including infants/toddlers who have a diagnosed condition but may not be demonstrating delays at the time of evaluation.
3. Are at significant biological risk of having substantial developmental delays if Early Intervention services are not provided.

Services are coordinated through community-based contractual arrangements, generally with behavioral health sites. However, toddlers receive the benefit of comprehensive, primary health screenings necessitating a linkage with the child's "medical home." Additionally, information gathered during the individual assessment plan and through the linkage with the primary care provider, is compiled to facilitate the child's access to Social Security Supplemental Income, as appropriate. Children referred from any MCH administered program are given expedited handling for SSI determination, based on an existing Memorandum of Understanding with the Social Security Administration.

Initial *System's Development* grant monies have enabled the Children's Specialty Care system to integrate many activities. For example, this unit works to identify community resources for families of children ineligible for specialty care. In addition, this unit works alongside the library/information resource system within MCH, to gather and distribute information about disease specific conditions; and to identify community resources for referral. It is also responsible for spearheading negotiations with the Social Security

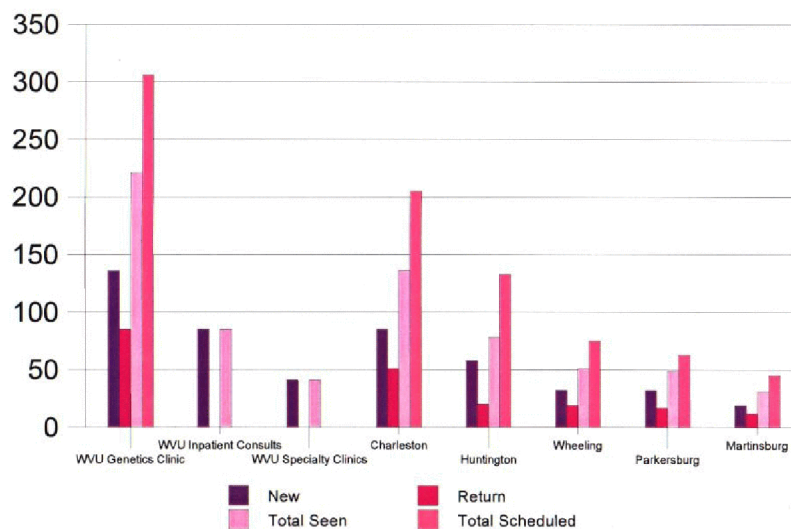
Administration which resulted in an expedited SSI application process for MCH-Children's Specialty Care participants. The unit has served as the data repository, collecting information about the demand for services which exceed current MCH program capacity; i.e., frequency of calls about asthma, diabetes. In FY 2000, the SSDI monies were used to support the block grant needs assessment; however, other sources were used to maintain the Single Point of Entry coordination functions initiated in earlier years.

The **Genetics Program**, administered by the West Virginia University (WVU), Department of Pediatrics, located in Morgantown, is the only in-state genetic service provider for the State of West Virginia. Services are provided through a network of satellite clinics in Charleston, Huntington, Parkersburg, Martinsburg, Charles Town, and Wheeling. These services are almost solely financed by Title V. The Genetics Program staff provides all technical guidance for the medical community when caring for children with metabolic disease.

During childhood, between 30 to 50 percent of hospitalized children are treated for genetic disorders, and two-thirds of all deaths in pediatric hospitals have a recognized genetic component (national statistic). Consequently, ongoing support for the Genetics Program is critical to maternal and child well-being. The team at WVU is an integral part of MCH programming, assisting with diagnostic services as well as intervention/counseling designed to reduce reproductive failures. Service availability and utilization are portrayed below.



GENETICS PATIENTS SEEN IN 1999



WVU/Department of Pediatrics/Genetics/04-00

1.5.1.3 Other Capacity

In all, there are 247 staff positions in West Virginia's Title V agency. Of these positions, 6 are senior management, 70 professionals, 33 medical professionals, 62 para-professionals, 56 clerical workers and another 20 are professionals under contractual hire. The biographical sketches of senior management are provided as attachments in Appendix A.

During Fiscal Years 1997 and 1998, two parent advisors were recruited by the Office of Maternal and Child Health, one as a paid employee and the other as a volunteer. These positions have been maintained, and additional parent-to-parent coordinators located in the community and hired through contract have been increased by three (3). Parent advisors are often trained alongside our developmental disabilities community related to advocacy, public presentation skills, and public policy development. The parent advisors participate in CSC clinical activities and document activities for inclusion in the medical records. Parent Advisor reports are color coded and used as documentation of additional service needs, such as specific medical information, special consideration requests, etc.

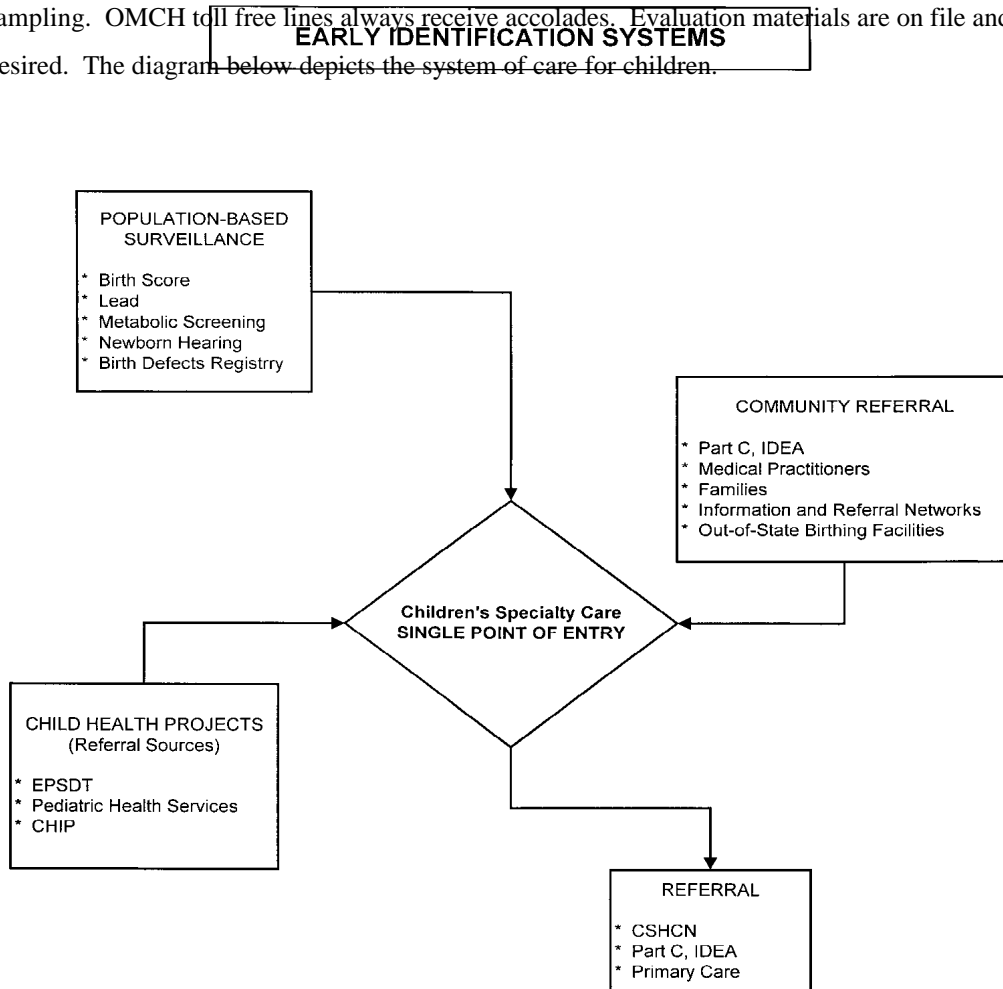
The Children's Reportable Disease Project recruited a parent volunteer for its SIDS Project. The SIDS parent is an active member of the SIDS Advisory Committee and is a parental contact for families who have experienced a recent SIDS death. This volunteer position is often hard to fill for a multiplicity of reasons, and at the time of this writing is vacant again.

1.5.2 State Agency Coordination

The Office of Maternal and Child Health has historically contracted with the Title XIX agency for the administration of EPSDT. In addition, there have also been formalized agreements for services offered through the Right From The Start Project, Family Planning and Children with Special Health Care Needs. The Office of Maternal and Child Health administers and participates in the coordination of programmatic services funded under Title XIX to prevent duplication of effort, as required by federal regulation (42 CFR §431.615(c)(4), see Memorandum of Understanding, dated July, 2000. The State of WV has long standing partnership arrangements with community health centers, details of which are outlined in the Primary Care Cooperative. These agreements are referenced as Appendix B. The Office of MCH also has administrative responsibility for service design and oversight for securing eye and vision care for persons moving from Welfare to work, and training of child care staff. These efforts are financed with TANF and Child Development Block Grant dollars; copies of the Memorandums of Understanding appear in Section 5.3, Appendix C.

The Office of Maternal and Child Health has in place many systems that contribute to the early identification of persons potentially eligible for services. These population based systems include birth score, birth defect registry, pregnancy tracking systems, metabolic screening, and most recently, newborn hearing screening. In addition, because we administer the EPSDT Program, children who have conditions that may

be debilitating and/or chronic disease, are referred to the Children's Specialty Care unit for further evaluation. This connection with EPSDT, which targets some 202,000 eligible children yearly, provides public health with a vehicle for identifying youngsters with problems, knowing that economically disadvantaged children are at increased risk. MCH, in an effort to increase public awareness, routinely participates in health fairs and community events. Our toll free lines, established in 1980, average 2,000 calls per month. Each caller receives individualized follow-up correspondence to assure the referrals and pertinent information related to the request met their need. Callers are also contacted by an administrative entity within MCH to ascertain the caller's satisfaction with our services. This quality assurance monitoring is prepared using random sampling. OMCH toll free lines always receive accolades. Evaluation materials are on file and available if desired. The diagram below depicts the system of care for children.



West Virginia Maternal and Child Health is known for its positive partnerships with the medical community, the University Affiliated Program, Department of Education, the March of Dimes Chapter, among others. These partnerships have resulted in shared initiatives. One initiative is the folic acid campaign, a national March of Dimes assignment, used in West Virginia to advocate for the distribution of this supplement preconceptually to reduce the incidence of neural tube defects.

Agency Partners

- 400+ medical contracts with private physicians, community health centers, local health departments and hospital based clinics for the provision of EPSDT.
- Contracts with the State's three (3) tertiary care facilities for skill-building related to provision of services to maternal and child health populations at the community level. These contractors also have responsibility to maintain systems of early identification of increased risk maternal and infant populations for diversion to appropriate care, tertiary as opposed to community hospital.
- 12 community-based contracts for provision of Birth to Three services.
- Memorandum of Understanding with WIC and SSA for referrals as referenced earlier.
- Working agreement with the Office of Social Services (Title IVB) for children in state custody to receive enhanced health screens through MCH's medical provider networks.
- Agreements with WVU for genetic services and administration of the Birth Score Project.
- 128 agreements statewide for Title X family planning services.
- 153 agreements statewide for breast and cervical cancer screening program services.
- Agreements with 7 agencies to administer the Right From The Start Project and subsequent agreements with 233+ agencies to provide direct services to perinatal populations.

Other partnerships include*:

- March of Dimes Board membership
- Developmental Disabilities Planning Council
- Medical Advisories for all programs and projects.
- University Affiliated Program, Consumer Advisory Council membership
- Interagency Coordinating Council for Birth to Three (state established statute)
- Healthy Schools
- Starting Point Centers (Early Childhood Initiative, initially funded with Carnegie Foundation monies.)
- Governor's Cabinet on Children and Families

- Head Start
- Cancer Coalition (established state statute)
- Membership, West Virginia Association of Community Health Centers

*List is not all inclusive.

II REQUIREMENTS FOR THE ANNUAL REPORT

2.1 Annual Expenditures

See Forms 3, 4 and 5.

2.2 Annual Number of Individuals Served

See Forms 6, 7, 8 and 9.

2.3 State Summary Profile

See Form 10.

2.4 Progress on Annual Performance Measures

NATIONAL PERFORMANCE MEASURES

Performance Measure 1: The percent of State SSI beneficiaries less than 16 receiving rehabilitative services from the State CSHCN Program.

Performance Objective: FY 1997: State Capacity

Performance Indicator: FY 1999: 43% (Source: Single Point of Entry - MCH data base)

Activities:

- The 1989 Omnibus Budget Reconciliation Act (OBRA) directed the establishment of an on-going program of outreach to children who are potentially eligible for SSI benefits. The West Virginia Office of Maternal and Child Health provides the following on-going activities to ensure eligible children/families are aware of SSI:
 - Families using Single Point of Entry are advised about SSI and how to apply, if appropriate. Single Point of Entry, staffed by social workers and nurses, is responsible for care coordination for populations ineligible for MCH services.
 - Families of children with chronic, debilitating conditions, using Children's Specialty Care, receive copies of their medical information, information on how to access SSI, and because of the Social Security Disability Determination-OMCH working agreement, the applications of families referred by MCH receive priority handling.
 - Children identified with chronic, handicapping conditions by virtue of an EPSDT screen are also referred to Single Point of Entry for assessment and as appropriate, to Social Security for SSI determination.
 - The community-based perinatal network, called Right From The Start, serves as an information conduit between community hospitals and tertiary care facilities to ensure "high risk" babies who are transferred into their communities are followed, and those who are cared for in neonatal intensive care are referred to SSI. The RFTS network also serves as an information source since they interface directly with families.
 - **MCH surveyed families with children under age 16 receiving SSI, by random sampling, to determine whether or not the population has a health home. The findings and methodology are reported in the needs assessment, with approximately 90% indicating they have a source of**

primary care.

Performance Measure 2: The degree to which the State's CSHCN Program provides or pays for specialty and subspecialty services, including care coordination, not otherwise accessible or affordable to its clients.

Performance Objective: FY 1997: State Capacity

Performance Indicator: FY 1998: 100% (12.0 out of a 12.0 possible score) (Source: Single Point of Entry)

Activities:

- Pediatric medical care is available in all parts of West Virginia, because it is provided in partnership with board certified physicians. These physicians are part of traveling "health delivery teams" serving professional shortage areas.
- The availability of care coordination for children with special health care needs is made possible by Title XIX and Title V financing, and is provided to all program participants regardless of payor status.
- In FY 2000 Pediatric Program Specialists have encouraged primary medical providers to identify high need children within their practices for referral and coordination of care to CSHCN. Medical practitioners will continue to see the population, with specialists augmenting services, with both working to maximize outcome.
- State code requires children referred for CSHCN be assessed for enrollment and/or diversion to other systems of care. Title V supports the "point of entry" that offers this care coordination/referral service.

Performance Measure 3: The percent of Children with Special Health Care Needs in the State who have a medical home.

Performance Objective: FY 1998: State Capacity

Performance Indicator: FY 1998: 99.5% (Source: MCH/CSC)

Activities:

- Beginning in FY 1998, whenever a child participating in the CSHCN Program presents for services, an intake question regarding the child's family physician is asked. This captures needed information on whether or not the child has a medical home and whether or not the child needs to be connected with one.
- In addition, OMCH has surveyed SSI recipients under the age of sixteen years to determine need. Survey details will be contained in the needs assessment. In short, there are 7,098 children under the age of 16 receiving SSI in the State of WV, 90% of whom responded affirmatively to having a health care home. In addition, all children participating in the CSHCN program must identify a health care home for basic primary, preventive care as referenced earlier. These two sources were used to obtain the performance indicator cited above.
- It is a matter of operational policy that care/medical records for services provided in CSC are shared with the

child's designated primary care physician.

Performance Measure 4: Percent of newborns in the State with at least one screening for each of PKU, Hypothyroidism, Galactosemia, hemoglobinopathies (e.g., the sickle cell disease) (combined).

Performance Objective: FY 1997: 95%

Performance Indicator: FY 1999: 95.1% (Source: MCH data base - Research)

Activities:

- In conjunction with the Office of Laboratory Services, the Newborn Screening Project ensures that infants are screened for inborn errors of metabolism before hospital discharge. All abnormal test results are followed-up by Maternal and Child Health staff and confirmed abnormalities receive case management, with assistance from the Genetics Program at WVU. The Office of Maternal and Child Health provides, free of charge, regardless of family income, formula for those with confirmed PKU.
- The pediatric genetics program at West Virginia University provides subspecialty clinics throughout the State for children identified with inborn errors of metabolism.
- MCH staff routinely visits birthing hospitals as a means of identifying and resolving any problems or concerns.
- In FY 1999-2000, the Provider Education team, comprised of three nurses, visited each of the state's 34 birthing facilities to provide in-service education on metabolic screening, reporting, and tracking.

Performance Measure 5: Percent of children through age 2 who have completed immunizations for Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.

Performance Objective: FY 1997: 90%

Performance Indicator: FY 1998: 93% (Source: Division of Surveillance & Disease Control)

Activities:

- While still below the targeted performance objective as set by Healthy People 2000, the percentage of children being fully immunized by the age of 2 years has increased substantially over time. In 1994, the percent of children fully immunized was 66 percent; in 1995, 68 percent; in 1996, 72 percent; and in 1997, 82 percent. The State's Immunization Program is not housed in the Office of Maternal and Child Health, but rather in the Office of Epidemiology and Health Promotion's Division of Surveillance and Disease Control. This program works closely with the State's local health departments, WIC, birthing hospitals, the private practicing medical community, and other early childhood initiatives in an effort to get as many children fully immunized as possible.

- The EPSDT Program also actively works to ensure that children participating in the program receive complete immunizations by age 2.

Performance Measure 6: The rate of births (per 1,000) for teenagers aged 15 through 17.

Performance Objective: FY 1997: 50

Performance Indicator: FY 1998: 25.8 (Source: Health Statistics Center)

Activities:

- There has been a steady decrease in the rate of births to teens in West Virginia. With teen pregnancy rates decreasing slowly, but steadily, the general public may falsely believe that sexual activity and pregnancy are no longer a problem in their community. **In 1996, the rate was 27.76 per 1,000 and in 1997, it was 26.7 per 1,000.** Multiple programs housed in the Office of Maternal and Child Health have contributed to this downward trend.
- In early 1999, administrative responsibility for an Adolescent Pregnancy Prevention Initiative was returned to the Family Planning Program to increase awareness about the problem of adolescent pregnancy in West Virginia. The primary objective of the Adolescent Pregnancy Prevention Initiative is to promote public awareness of adolescent pregnancy prevention and related issues through community education and outreach activities for community groups, schools, health care professionals, parent groups, and businesses (i.e., statewide Adolescent Pregnancy Prevention Conference, media campaign, posters, displays, and workshops.
- The Adolescent Health Initiative employs eight (8) Adolescent Health Coordinators in local communities to encourage the postponement of parenthood through a variety of behavioral (health) activities.
- The State's Family Planning Program offers confidential contraceptive health services to income eligible adolescents, with special emphasis on postponement of sexual activity, handling/discouraging sexual coercion, and the importance of family involvement in sexual decision-making. In CY 1999, this program served a total of 7,496 female teens and 248 male teens, for a total of 7,744 teens between the ages 15 to 17 years.
- Through the Adolescent Pregnancy Prevention Initiative and the Adolescent Health Initiative, the OMCH collaborates with the WV Department of Education to promote increased awareness of the consequences of adolescent pregnancy, the need for enhanced preventive services, and expanded youth development activities.

Performance Measure 7: Percent of third grade children who have received protective sealants on at least one permanent molar tooth.

Performance Objective: FY 1997: 50%

Performance Indicator: FY 1999: 38% (Source: MCH Dental Survey)

Activities:

- The Children's Dentistry Program is housed in the Office of Maternal and Child Health. This program provides preventive guidance to children and their parents regarding good oral hygiene and dental practices such as protective sealants. In FY 1998, this program provided over 8,631 dental sealants for low income children.
- In 1998, West Virginia conducted a population-based oral health needs assessment of school aged children, which appears in the Needs Assessment under population-based services.

Performance Measure 8: To reduce the rate of deaths to children aged 1-14 caused by motor vehicle crashes.

Performance Objective: FY 1996: 3.5 per 100,000

Performance Indicator: FY 1998: 15.15 per 100,000 (Source: Health Statistics Center)

Activities:

- In October, 1997, the Division of Rehabilitation Services (DRS) received a planning grant from the U.S. Department of Health and Human Services to assess the current Traumatic Brain Injury (TBI) needs and resources; gaps in services and develop a strategic plan for the State. MCH and the University Affiliated Programs are all partners in the implementation, which also has a prevention component.
- The EPSDT Program provides, through its FOW's, preventive guidance to parents about childhood injury that may result in death.
- The Adolescent Health Initiative developed a teaching module called "Head Over Wheels," which encourages the use of helmets as a means of preventing TBI.
- At the time of discharge, all birthing hospitals in the State issue an infant car seat.
- WV Youth Risk Survey information for 1999 reports that 20.7% of WV youth report that they rarely or never use seatbelts. The State of West Virginia now has a mandatory seatbelt law, which was strongly advocated for by the Bureau for Public Health and other medical partners.

Performance Measure 9: Percentage of mothers who breast-fed their infants at hospital discharge.

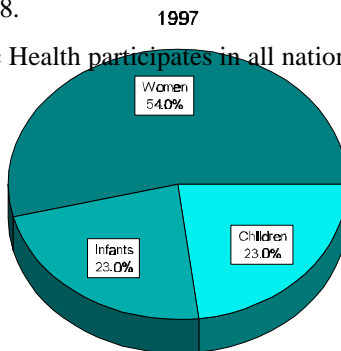
Performance Objective: FY 1997: 75%

Performance Indicator: FY 1998: 53.58% (Source: WV PRAMS Data)

Activities:

- While the latest data on breast-feeding indicates that a low percentage of women chose to breast-feed their infants, this should not be taken as an indication of little effort on the part of the State's Bureau for Public Health or, in particular, the Office of Maternal and Child Health. All pregnant women participating in the Office of Maternal and Child Health's Right From The Start Project receive information about the benefits of breast-feeding their infants.
- In addition, the State's Office of Nutrition Services, which administers the WIC Program, promotes breast-feeding and has on staff a Lactation Specialist. In addition, as stated previously, all pregnant women participating in Right From The Start or identified to public health, are referred to WIC. In 1998, WIC served 17,694 pregnant women, and as indicated, WIC educational efforts strongly emphasize the importance of breast-feeding. According to WIC data, 1,980 women participating in WIC post-partum services were breast-feeding mothers in 1998.

WV WIC RECIPIENTS BY TYPE



- Further, the Bureau for Public Health participates in all national breast-feeding media campaigns.

WV Office of Nutrition Services

Performance Measure 10: Percentage of newborns who have been screened for hearing impairment before hospital discharge.

Performance Objective: FY 2000: 100% of all Resident Births

Performance Indicator: FY 1998: 35% (Source: WV Hospital Association)

Activities:

- Even though a very small percentage of newborn infants have historically been screened for hearing impairment before hospital discharge, new legislation should change this over the next few years. In 1998, West Virginia House Bill 2388, established a mandate for the universal testing of newborns for hearing loss, effective July, 2000. Authority and oversight for the newborn hearing screening program rests with the Commissioner for the Bureau for Public Health who has been charged with establishing a Newborn Hearing Advisory to provide guidance and advice regarding program protocols.

- Effective July 1, 2000, all WV birthing facilities were screening.

- The OMCH Provider Education unit visited each facility to provide technical assistance related to this project. Subjects included how to screen, screening and reporting protocols, resource directory of available diagnostic testing sites, and tracking/intervention plans offered by MCH and the RFTS provider network.
- Pediatric Program Specialists have also distributed the provider resource guide which contains information about RFTS staff serving the area, availability of diagnostic service providers, etc.
- A patient education brochure has been developed and distributed throughout the service community.

Performance Measure 11: Percent of Children with Special Health Care Needs in the State CSHCN Program with a source of insurance for primary and specialty care.

Performance Objective: FY 1998: State Capacity

Performance Indicator: FY 1999: 81% (Source: MCH data base - CSC)

Activities:

- All children/families are assisted with accessing health care financing. This is not only in the child/family's interest, but assures maximization and efficient use of state resources.
- Children from families without coverage are referred to local DHHR offices in their county of residence to apply for Medicaid/CHIP.
- Staff of MCH programs are trained on eligibility requirements for accessing government financed health care.
- Families are provided technical guidance as to specific information required to apply for SSI, Medicaid/CHIP; i.e., income verification, identification, etc.
- Children denied Medicaid or CHIP with family income at or below 185% FPL, as determined by local DHHR offices, are enrolled in CSHCN, **if they have a medically qualified condition.**

Performance Measure 12: Percent of children without health insurance.

Performance Objective: FY 1997: State Capacity

Performance Indicator: FY 1999: 12% (Source: WV Kids Count Data Book)

Activities:

- MCH has no formal role in CHIP, in spite of our 25 years of experience in outreach and success, as demonstrated by our previous year's EPSDT utilization rate of 73.7%, while the national average in 1996 was 37%. (Source: Children's Health Under Medicaid: A National Review of EPSDT, National Health Law Program, Chapel Hill, N.C.)
- We continue to use MCH resources to assist local health departments in developing billing capacity, marketing plans, etc. that will allow them to continue clinical care. Given the State's lack of professional medical services, this is important, if the children without health care financing are to receive services.
- MCH Medical Advisory members have been enlisted to present information about EPSDT, WV-CHIP, , etc. during AAP, FAAP State Chapter meetings, etc.
- CHIP has recently expanded eligibility to 200% FPL. The enrollment of children within this income group

is targeted for November 2000.

Performance Measure 13: Percent of potentially eligible children who have received a service from Medicaid.

Performance Objective: FY 1997: 100%

Performance Indicator: FY 1999: 61% (Source: EPSDT Screens documented on the HCFA 416 Report; Medicaid Births/Vital Statistics)

Activities:

- The proportion of eligible children receiving EPSDT/Medicaid has ranged over the past several years from a low of 53 percent to a high, in 1998, of 73.7 percent. The EPSDT Program, administered by the Office of Maternal and Child Health, provides dedicated outreach to eligibles in order to encourage participation (see the activities discussed under State Performance Measure 8).
- The OMCH administers the EPSDT Program, and uses the outreach requirement of the federal legislation to encourage families with children to participate in routine, primary preventive care. Our staff, in 1998-99, initiated 50,000 home visits, while our Program Field Specialists exceeded their assignment of two times per year contact with program participating medical providers. The total number of technical assistance trainings face-to-face with the medical community was 1,724.
- Infants whose birth was sponsored by Medicaid and served by RFTS was 36% of all Medicaid sponsored births.
- Approximately 57.19% of all state births were to Medicaid sponsored women, and all infants born to mothers with Medicaid coverage are eligible for Medicaid for the first year of life.

Performance Measure 14: The degree to which the State assures family participation in program and policy activities in the State CSHCN Program.

Performance Objective: FY 1997: State Capacity

Performance Indicator: FY 1999: 60% (10.8 out of 18.0 possible points)

Activities:

- In Fiscal Year 1997, the Division of Children's Specialty Care hired a parent advisor/consultant to provide a parent's perspective for committees, policies and procedures and to act as a liaison for the CSC Division. Specific duties include recruitment of additional parent advisors. Monies were placed in the WVU-UAP agreement for the hire of three additional **parent advisors**, and as of this writing, two of the three additional positions have been filled. (**Cue:** This does not include other parent advisors involved in SIDS, Part C-IDEA, etc.)
- Parent/child participates in the assessment process and in the development of agreed upon care plans. The parent, or if age-appropriate, the child, must sign care plans as evidence of their role in addressing identified

issues.

- CSC draft policies for early intervention (Part C), CSHCN, etc. are shared with partners in the developmental disability community, including the **Developmental Disabilities Council, Family Voices, the Early Intervention Interagency Coordinating Council**, etc. for input prior to finalization.
- The OMCH is represented on the **UAP Consumer Advisory**. A recent training initiative has been developed called Impact 2000, which is responsible for preparing higher education faculty throughout West Virginia on ways to promote inclusion of persons with disabilities. This has major implications for the School of Medicine since we are reliant on them for many of our pediatric sub-specialty services for children in specialty care.
- The **Early Intervention Interagency Coordinating Council**, sub-committee on policy, serves as a policy development forum for early intervention programming. The ICC is comprised of agency partners, legislators, and parents.
- The **Developmental Disability community** also assisted MCH as advocates, resulting in the successful passage of newborn hearing screening and birth scoring legislation.
- **Camp Gizmo**, a hands-on learning opportunity for parents, professionals, and siblings of children who require the use of assistive technology, is held yearly. The camp is an interagency activity sponsored by OMCH, **Autism Training Center**, and the **West Virginia Parent Training and Information Center**.
- OMCH provides funding support for the publication, "Parent Connection," produced by WVU Department of Pediatrics but prepared by and for consumers.
- The project, **Parent Partners in Education (PPE)**, teaches doctors what it is like to live with and raise a child with a chronic disorder. The goal of the project is to improve the medical practitioner's ability to communicate and collaborate with families of children with special health care needs. Pediatric-family practice residency programs participate in the project using a modified curriculum based on Project Delivery of Chronic Care initiated by N. Shore, Long Island Jewish Hospital in New York.
- Although family members sit on established advisory committees such as the Interagency Coordinating Council for Part C, CSHCN Advisory, etc., we also pay family members as hired staff, see UACDD/UAP earlier reference.
- Because it is important for families to have roles independent of affiliation with MCH, we have supported **parent stipends for self-advocacy and leadership skill building by pooling resources with the Department of Education - Special Education, Developmental Disabilities Council, and Fairshake Network** which is an advocacy organization for persons with developmental disabilities.
- Further, to ensure parents' roles as the care coordinators for young children with disabilities, the Parent Advisor for CSC developed a care plan notebook for family use in compiling and tracking services.
- CSHCN program encourages youth to participate in self-advocacy skill building opportunities offered by the Fairshake Network. This is an integral part of establishing the youth's progression toward self-sufficiency

and self-determination. The Fairshake Network is a coalition of consumers who hold workshops, skill-building seminar and function as advocates on disability issues.

- Children with Special Health Care Needs Program nurses, social service workers, serve on the Board of the Mountaineer Camp established in 1985. This camp serves children and teenagers between the ages of 8 and 18 who have myelodysplasia and spina bifida. These same nurses, social service workers, along with support staff, spend one week yearly helping children and teens to develop self esteem, social skills, and independence while participating in recreational and social activities.

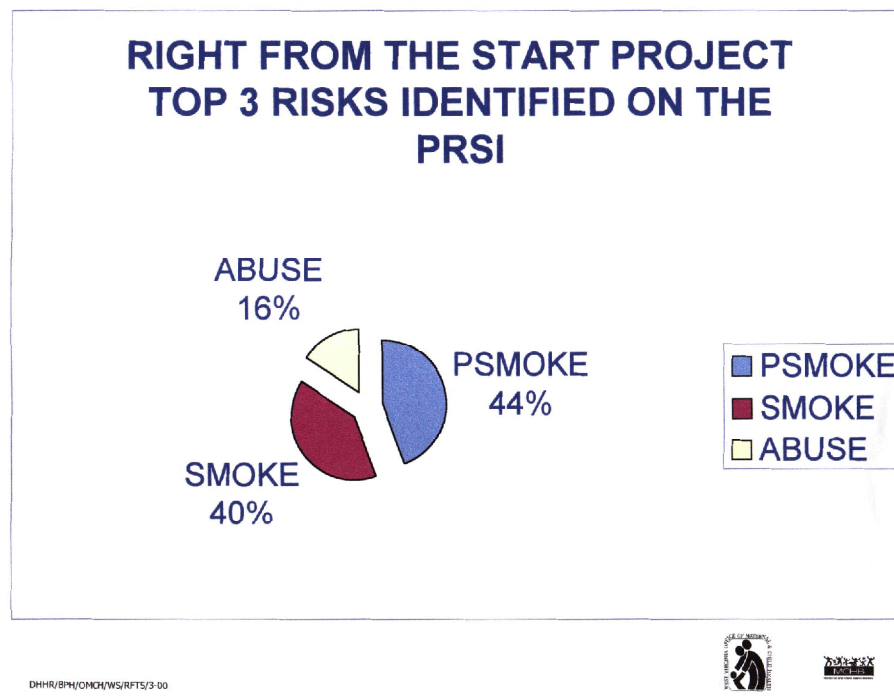
Performance Measure 15: Percent of very low birth weight live births.

Performance Objective: FY 1996: 1.0%

Performance Indicator: FY 1998: 1.5% (Source: Health Statistics Center)

Activities:

- While the proportion of very low birth weight live births is higher than the objective set by Healthy People 2010, the proportion is still relatively low. The Office of Maternal and Child Health's perinatal program, Right From The Start, provides pregnancy risk assessments, called Pregnancy Risk Survey Instrument (PRSI), for all income eligible pregnant women. The risk assessments, as well as additional enhanced services, identify and then attempt to educate all pregnant women identified as being at-risk for poor pregnancy outcomes.



- Pregnant women are routinely referred to WIC and receive in-home nutrition support provided by Right From The Start community-based personnel. Personnel providing RFTS are licensed social workers or nurses.
- The high incidence of low birthweight is concentrated in a small number of counties. Activities to address this include Right From The Start follow-up to discuss nutrition during pregnancy and enrollment in WIC.
- The Perinatal and Women's Services unit has also hired a staff person solely dedicated to teen pregnancy prevention efforts, as referenced earlier. These efforts include sex education/instruction in partnership with public schools. Planning and spacing for pregnancy seems to be the key to reducing low birth weight incidence.
- In 1998 there were 309 very low birth weight infants (<1500 grams), with the majority born to persons above the age of 15 years.
- Further, West Virginia data confirms that very low birthweight infants are born to younger age women, the population that we are focusing on through abstinence education, teen pregnancy prevention, and adolescent asset building.
- Birthweight data, by smoking mothers, cited below, also confirms a West Virginia problem.

Birthweight by smoking habits (did smoke) three months before pregnancy.		
Year	Low (<2500 grams)	Normal (>2500 grams)
1996	53.40%	39.13%
1997	45.07%	31.39%
1998	52.85%	40.51%

PRAMS Data/REP/05-2000

Performance Measure 16: The rate (per 100,000) of suicide deaths among youths aged 15-19.

Performance Objective: FY 1996: 8.2 per 100,000

Performance Indicator: FY 1998: 20.7 per 100,000 (Source: Vital Statistics Center, OEHP)

Activities:

- Total suicides decreased by 37 (261 to 224 or 14.2% between 1997 and 1998). The average age of death for a suicide victim in 1998 was 45.4 years. While suicide was the ninth leading cause of death overall, it was the second leading cause of death to persons 15 to 34 years. **The number of suicides among persons age 19 and under rose by 1, from 16 in 1997 to 17 in 1998.**
- The Office of Maternal and Child Health's Adolescent Health Initiative provides, through the Adolescent Health Coordinators located throughout the State, increased awareness of adolescents about at-risk behaviors leading to injury, disease and death. These Coordinators provide technical assistance to youth leaders and

school teachers. Among these at-risk behaviors are those which can lead to suicide. The Coordinators' work activities involve programs and services to reduce adolescent at-risk behavior.

- The state has 18 licensed behavioral health centers (mental health) available to provide services for the population identified as in need of mental health services. The EPSDT screen actually contains a behavior assessment instrument used for the populations above age 10 years.

Performance Measure 17: Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.

Performance Objective: FY 1996: 90%

Performance Indicator: FY 1998: 81.8%

Activities:

- The Office of Maternal and Child Health's perinatal program, Right From The Start Project, provides pregnancy risk assessments for all government sponsored pregnant women. Early identification efforts have resulted in increased numbers of very low birth weight infants being delivered at the State's tertiary care facilities.
- The Office of Maternal and Child health staff has repeatedly urged all pregnant women, regardless of income, to be risk screened. This has involved meetings with PEIA and the Insurance Commissioner.
- The lack of birthing facilities in every county creates a reluctance on the part of the State's tertiary care facilities to take marginal risk patients; yet it is impossible to predict every high risk patient/condition.
- We continue to fiscally support training teams, based at the tertiary facilities, who work with community hospitals, encouraging early identification and referral of high risk perinatal populations. These teams are called Perinatal Outreach Projects.

Performance Measure 18: Percent of infants born to pregnant women receiving prenatal care during the first trimester.

Performance Objective: FY 1997: 90%

Performance Indicator: FY 1998: 80.05% (*PRAMS Data*)
80.1% (*Vital Statistics Data*)

Activities:

- One among the many issues of concern with unintended pregnancy is the receipt of first trimester prenatal care. The table below presents PRAMS data from 1991 through 1998 on the proportion of pregnancies by intendedness receiving first trimester prenatal care.

- For all women of child-bearing years, unintended pregnancy is an important issue. The consequences of an unintended pregnancy are serious, imposing appreciable burdens on children and families.
- There is a positive trend in the proportion of all pregnancies – intended and unintended – receiving first trimester prenatal care. For instance, between 1991 and 1998 there has been an overall 18 percent increase in the percentage of women with unintended pregnancies receiving first trimester prenatal care. Additionally, there has been a corresponding 14 percent increase in the percentage of women with intended pregnancies receiving first trimester prenatal care. However, despite these positive trends, it remains the case that women with intended pregnancies are more likely than their counterparts with unintended pregnancies to seek first trimester prenatal care. As the data table depicts, in each year examined, there is a dramatic difference between the percentage of women with intended pregnancies receiving first trimester prenatal care and women with unintended pregnancies receiving first trimester prenatal care.

Percent of Women Receiving 1st Trimester Prenatal Care by Pregnancy Intendedness* 1991-1998 PRAMS DATA		
Year	% Intended Pregnancies Receiving 1st Trimester Prenatal Care	% Unintended Pregnancies Receiving 1st Trimester Prenatal Care
1991	72.41	52.93
1992	77.86	53.32
1993	80.20	55.11
1994	79.05	62.07
1995	81.80	65.20
1996	84.67	63.95
1997	88.55	69.44
1998	87.10	71.03

*Intended refers to the pregnancy was wanted sooner or then/Unintended refers to wanting the pregnancy later or not wanted at all.

- The Family Planning Program provides free pregnancy testing at all sites in an effort to improve early identification and referral of pregnant women into care.
- Women who have positive pregnancy tests completed at one of our 128 sites statewide are immediately assisted with completing a shortened Medicaid application, linked to a physician, with initial care cost defrayed by Title V, etc., if they do not have health care financing.
- Pregnancy testing and verification required for Medicaid eligibility is provided at no charge to women,

without regard to income, at all 128 community-based sites.

- To increase the number of women receiving prenatal care during their first trimester of pregnancy, the Office of Maternal and Child Health's Right From The Start Project provides comprehensive perinatal services to low income women, including direct financial assistance for adolescents and non-citizens who are ineligible for Medicaid, but whose income is equal to or less than 185 percent of the Federal Poverty Level; limited coverage for prenatal patients who at the time of first prenatal visit have not received a Medicaid card and are subsequently denied, or prenatal patients whose Medicaid coverage is not backdated to cover the first visit and initial laboratory services. In FY 1999, approximately 50% of all pregnant women in the State received some *direct* service from this Project.
- The OMCH works in concert with the West Virginia Chapter of the March of Dimes to ensure information about the need for early and continuous care is provided throughout the State. This partnership supports a population-wide education effort.
- Ten counties that have 20% or more births to women with second or third trimester care have been identified for additional targeting of resources. OMCH staff have increased visits to local Department of Health and Human Resources offices which determine the Medicaid eligibility, again reminding field staff that if a pregnant woman is ineligible for Medicaid, her application is to be sent to MCH for case management.
- All medical providers and all local Department of Health and Human Resources offices have been visited to remind them of the above MCH policy; that is, MCH will pay for the initial prenatal visit and all initial outpatient lab without benefit of any financial declaration for any medically indigent women.
- The OMCH also works in concert with the Divisions of Primary Care and Recruitment to develop capacity specific to the professional shortages; i.e., obstetrics.

STATE NEGOTIATED PERFORMANCE MEASURES

Performance Measure 1: Percent of age appropriate children (ages 6 months through 6 years) screened for blood lead.

Performance Objective: FY 1997: 25%

Performance Indicator: FY 1999: 9.14%

Activities:

- Childhood Lead Poisoning and Prevention Project (CLPPP) and Research, Evaluation and Planning Division staff developed and continued to refine an active surveillance system with all laboratories for mandatory reporting of blood lead testing results to the Office of Maternal and Child Health. These population-based surveillance activities are coordinated by the pediatric field staff as a part of medical provider orientation, monitoring and technical assistance.
- The CLPPP's multi-faceted public and professional education and health communication efforts in FY 1999

included: 1) six booth presentations; 2) four trainings were offered for CEU's to nurses, sanitarians, and social workers; and 3) two trainings with CME's were offered to physicians.

- The CLPPP has been providing technical assistance to elementary schools and child care service sites, including Starting Point Centers and Head Start on a statewide basis. In addition to these efforts, public presentations have occurred at forums made available by local church groups and through parent advisories of agencies responsible for children's health services and/or child care. Approximately 1,200 persons have attended these learning opportunities.
- The CLPPP worked with local health departments to develop and implement a community-level case management system which relies on both local health department nurses and sanitarians. To date, 41 out of the State's 49 local health departments have signed letters of agreement to provide case management for children identified with elevated blood levels.

Performance Measure 2: Percent of women ≥ 18 receiving a Pap smear within the preceding three years.

Performance Objective: FY 1997: 85%

Performance Indicator: FY 1999: 80.7%

Activities:

- Vital Statistics report of health screening preliminarily confirms that 80.7% of WV women ≥ 18 years of age with intact cervix received a Pap smear.
- In FY 1999, the Breast and Cervical Cancer screening Program screened 2,855 women between the ages of 18 and 49; 1,054 women aged 50 through 64; and 18 women over 65 years of age for cervical cancer. Additionally, 3,919 women between the ages of 18 and 49 were re-screened; 2,642 women aged 50 through 64 were re-screened; and 74 women over 65 years of age were re-screened. These women were all uninsured or underinsured for these services.
- In CY 1999, the Family Planning Program provided Pap smears for 52,225 low-income uninsured women receiving contraceptive services.

Performance Measure 3: Percent of women ≥ 50 years of age receiving a mammogram within the preceding two years.

Performance Objective: FY 1997: 75%

Performance Indicator: FY 1999: 71.9%

Activities:

- Vital Statistics report that 71.9% of WV women received a mammogram within the preceding two (2) years and that in the same time period 65.7% received both a mammogram and a clinical breast exam/evaluation.

- In FY 1999, the Breast and Cervical Cancer Screening Program screened 1,701 women between the ages of 18 and 49; 1,209 women aged 50 through 64; and 25 women over 65 years of age for breast cancer. Additionally, re-screening for breast cancer were provided for 1,808 women between the ages of 18 and 49; 3,701 women aged 50 through 64; and 124 women over 65 years of age. These women were all uninsured or underinsured for these services. **The policy decision by HCFA to cover mammography services for Medicare recipients without deductibles, etc. has changed the number of women participating in Breast and Cervical Cancer Screening Program activities. The federal policy decision has resulted in women being able to access this vital service without program support from the BCCSP financed by CDC. The State of WV has repeatedly asked to have access to Medicare data to reflect the number of women accessing mammography services, subsequently paid for by Medicare.**

Performance Measure 4: Percent of women receiving first trimester prenatal care whose prenatal care is being paid for by Medicaid.

Performance Objective: FY 1997: 90%

Performance Indicator: FY 1998: 74.41% (Source: PRAMS)

Activities:

- While 83 percent (83.7%) of all pregnant women in the State received first trimester prenatal care in FY 1998, a substantially lower proportion of women whose prenatal care is being paid for by Medicaid received first trimester prenatal care. Nevertheless, trend data indicate that the proportion of such women has increased steadily over the years. Contributing to this substantial increase is the State's Right From The Start Project (see activities listed under National Core Performance Measure 18), and free pregnancy testing offered by Family Planning, referenced earlier.
- In addition to first trimester prenatal care being a factor associated with intendedness of pregnancy, payor source for deliveries is as well. The table below presents PRAMS data from 1991 through 1998 on the percent of deliveries of unintended pregnancies with prenatal care paid for by either Medicaid or other insurance.

Percent of Deliveries of Unintended Pregnancies of West Virginia Women with PNC Paid for by Either Medicaid or Other Insurance* 1991-1998 PRAMS Data		
Year	% Deliveries of Unintended Pregnancies PNC Paid for by Medicaid	% Deliveries of Unintended Pregnancies PNC Paid for by Other Insurance
1991	67.34	32.66
1992	70.33	29.67

Percent of Deliveries of Unintended Pregnancies of West Virginia Women with PNC Paid for by Either Medicaid or Other Insurance* 1991-1998 PRAMS Data		
Year	% Deliveries of Unintended Pregnancies PNC Paid for by Medicaid	% Deliveries of Unintended Pregnancies PNC Paid for by Other Insurance
1993	72.51	27.49
1994	76.96	23.04
1995	78.15	21.85
1996	69.92	30.08
1997	68.27	31.73
1998	72.32	27.68

*Intended refers to the pregnancy was wanted sooner or then/Unintended refers to wanting the pregnancy later or not wanted at all.

- Women who access medical care, but have no source of coverage at the initial visit are referred to MCH by the medical community for care management. Also referenced earlier, MCH serves as the initial payor for the patient's preliminary care, while exploring all health financing options.

Performance Measure 5: Percent of unintended pregnancies.

Performance Objective: FY 1997: 41.7%

Performance Indicator: FY 1998: 37.13% (Source: PRAMS)

Activities:

- The Office of Maternal and Child Health, Family Planning Program offers free contraceptive care to persons with income at or below 100% FPL at 128 sites. In CY 1999, 60,937 women, men and adolescents of all ages received Family Planning services. Approximately 51,949 of these clients lived in households with incomes at or below 100 percent of the federal poverty level, 6,264 lived in households at or between 101 and 150 percent of the federal poverty level, 1,969 lived in households at or between 151 and 200 percent, and 4 lived in households with incomes between 200 and 250 percent of the federal poverty level.
- Eighty-seven percent (87%) of Family Planning Program participants used some form of contraception.
- School-based health sites are administered by primary care agencies that are also family planning providers for adolescent referral.
- MCH has aggressively marketed to Medicaid the need to expand Medicaid coverage to postpartum women for a period of at least two years. Women receiving Medicaid coverage for pregnancy-related care currently

- lose these benefits 60 days following childbirth, placing them at risk of unintended pregnancy.
- MCH has received TANF resources to support in-service training about the availability of family planning services statewide. These in-service education efforts were for TANF workers, called Family Support Specialists, who are responsible for case management as clients transition from Welfare to work.

Of All West Virginia Pregnancies by Year Percent Intended and Percent Unintended* 1991-1998 PRAMS Data		
Year	% Intended Pregnancies	% Unintended Pregnancies
1991	59.23	40.77
1992	58.62	41.38
1993	58.02	41.98
1994	59.42	40.58
1995	54.79	45.21
1996	57.95	42.05
1997	58.30	41.70
1998	62.87	37.13

*Intended refers to the pregnancy was wanted sooner or then/
Unintended refers to wanting the pregnancy later or not wanted at all.

Performance Measure 6: The positivity of females ages 15-19 years of age who have contracted Chlamydia.

Performance Objective: FY 1997: a positivity rate of no more than 3.5% for females ages 15-19

Performance Indicator: FY 1999: 2.97% (Source: WV Chlamydia Project data)

Activities:

- The Office of Maternal and Child Health's Family Planning Program continued to monitor the incidence of Chlamydia in all program participants, providing 13,500+ Chlamydia tests for females ages 15-19 in CY 1999.
- The Family Planning Program continues participate in the Region III Chlamydia Demonstration Project providing statewide screening and diagnosis for clients in all Family Planning clinics. All clients with positive test results were provided treatment medications free of charge. The WV STD Program provides partner notification support to Family Planning clinics and patients , if needed.

Performance Measure 7: The percent of women not smoking during pregnancy.

Performance Objective: FY 1997: 90%

Performance Indicator: FY 1998: 74.6% (Source: WV PRAMS)

Activities:

- Smoking during pregnancy continues to be a health problem for women in West Virginia despite multiple efforts at educating women of reproductive age of the poor pregnancy outcomes and potential risks smoking

has on their own and their children's health.

Smoking Habits (PRAMS Data)			
Year	Smoked 3 Months Before Pregnancy	Smoked Last 3 Months of Pregnancy	Smokes Now (After Pregnancy)
1996	40.17%	28.03%	32.81%
1997	32.45%	23.89%	29.25%
1998	41.42%	27.67%	35.22%

Maternal age by Smoking Habits (did smoke) Three Months Before Pregnancy (PRAMS Data)				
Year	≤ 18 Years of Age	19-24 Years	25-34 Years	35 and Older
1996	60.04%	49.70%	29.12%	35.66%
1997	50.86%	41.51%	23.05%	24.83%
1998	58.33%	53.37%	29.94%	28.60%

e.g. Of mothers ≤ 18 years of age, 60.04% smoked 3 months before pregnancy.

Maternal Education by Smoking Habits (did smoke) Three Months Before Pregnancy (PRAMS Data)		
Year	≤ High School Diploma	> High School Diploma
1996	52.39%	19.48%
1997	41.75%	17.35%
1998	53.84%	21.10%

e.g. Of mothers with ≤ high school education, 52.39% smoked 3 months before pregnancy.

- All pregnant women participating in the State's Right From The Start Project receive a pregnancy risk assessment and are offered enhanced services such as smoking cessation classes. In FY 1998, over 13,297 women participated in the Right From The Start Project.
- The Office of Maternal and Child Health actively collaborates with the Health Promotion Division of the Office of Epidemiology and Health Promotion to distribute literature on the harmful effects of smoking during pregnancy.
- The Office of Epidemiology and Health Promotion, using Tobacco Settlement monies has hired a Smoking and Pregnancy Coordinator. This individual will be working alongside RFTS to reduce the incidence of

smoking among WV women of childbearing age.

- The State of West Virginia's Tobacco Coalition has aggressive anti-smoking/anti-tobacco campaigns, including media and billboards.
- The West Virginia Department of Education, in coordination with CDC's Division of Adolescent and School Health and the Office of Smoking and Health has developed training for teachers and other personnel to prevent and reduce tobacco use among youth. While this is not specific to women during pregnancy, it is an effort to prevent early on-set of tobacco use, and may subsequently affect utilization levels over the lifespan.
- The Office, using PRAMS data, has been assessing smoking habits; before, during and after pregnancy in relation to other variables, as portrayed in earlier charts.

Prevalence of Current Cigarette Smoking by Selected Characteristics 1998 West Virginia Behavioral Risk Factor Survey			
Characteristic	Men	Women	Total
	29.7	26.4	27.9
<u>Age</u>			
18-24	35.3	34.8	35.1
25-34	31.4	35.8	33.6
35-44	36.7	37.9	37.3
45-54	30.1	24.4	27.2
55-64	29.0	22.0	25.3
65+	15.6	10.4	12.5
<u>Education</u>			
<12 Years	38.7	32.2	35.3
12 Years	31.3	27.4	29.3
13-15 Years	25.0	29.0	27.4
16+ Years	19.7	11.2	15.7
<u>Income</u>			
<\$15,000	41.4	34.8	37.4
\$15,000 - \$24,999	34.7	33.3	34.0
\$25,000 - \$49,999	23.0	22.1	22.5
\$50,000+	26.3	15.4	21.2

Office of Epidemiology & Health Promotion

Performance Measure 8: The percentage of eligible children receiving EPSDT services.

Performance Objective: FY 1997: 50%

Performance Indicator: FY 1998: 53.7%

Activities:

- The EPSDT Program's Family Outreach Workers actively engage in outreach activities to encourage parents of Medicaid-sponsored children to use EPSDT services.
- The EPSDT Program established a 1:500 provider:eligible child ratio and identified the existing ratio of providers to eligible children by region, targeting underserved areas in the State for intensive recruitment activities by Program Specialists.
- Since 1995, the EPSDT Program has worked to increase the number of school sites providing EPSDT services to eligible children, enabling greater access to preventive health care.
- The State of West Virginia's Office of Maternal and Child Health and Office of Social Services established as a special screening priority, children in state custody (Foster Care). Special care protocols and training have been negotiated for care of the State's children within the network of EPSDT providers.
- **The number of children eligible for EPSDT increased by 25% in FY 1999, reducing the percentage of utilization, although more than 112,000+ children received full screens.**

2.5 Progress on Outcome Measures

NATIONAL CORE OUTCOME MEASURES

Outcome Measure 1: The infant mortality rate per 1,000 live births.

Outcome Objective: FY 1996: 7 per 1,000

Outcome Indicator: FY 1998: 8.1 per 1,000

Outcome Measure 2: The ratio of the black infant mortality rate to the white infant mortality rate.

Outcome Objective: FY 1996: No Definition

Outcome Indicator: FY 1997: 1.325 to 1 per 1,000

Outcome Measure 3: The neonatal mortality rate per 1,000 live births.

Outcome Objective: FY 1996: 4.5 per 1,000

Outcome Indicator: FY 1998: 4.6 per 1,000 (95 deaths)

Outcome Measure 4: The postneonatal mortality rate per 1,000 live births

Outcome Objective: FY 1996: 2.5 per 1,000

Outcome Indicator: FY 1998: 3.5 per 1,000

Outcome Measure 5: The perinatal mortality rate per 1,000 live births

Outcome Objective: FY 1996: No Definition

Outcome Indicator: FY 1998: 0.6 per 1,000 (220 deaths) (Source: Health Statistics Center)

Activities: The first five Outcome Measures, all dealing with some degree of infant mortality, share the same range

of activities by the State's Title V agency.

- Pregnant women participating in government sponsored health care are screened for high risk conditions. Care plans and behavioral health interventions offered are dictated by these findings.
- The State's Right From The Start Project funds care coordination services provided by community-based agencies for infants determined to be at-risk by the Birth Score Program or by other population surveillance efforts.

West Virginia 1999 Raw Data Stats - Birth Score Office		
Item	Number	Percent
Number of WV Births Screened	21,257	N/A
WV Residents Only High Birth Score	2,914	16%
WV Developmental Risk (High and Low)	307	1.4%
NICU Referrals to RFTS (High, Low and Non-Scored)	600	2.8%
High Birth Score Referrals to RFTS (Non-NICU)	1,262	43.5%
High Birth Score Referrals to Outreach Staff (FOW's)	1,627	55.8%
Alternate Entry Referrals to RFTS (High, Low and Non-Scored)	624	2.1%

- To identify and provide necessary services for infants at-risk for morbidity and mortality, the Office of Maternal and Child Health, in conjunction with West Virginia University's Department of Pediatrics, scores every birth through the Birth Score Program. High scoring infants are connected with community-based services for care coordination, as well as an accelerated number of pediatric medical visits until the infant reaches his or her first birthday. In FY 1998, the Birth Score Program was placed in State statute mandating that each newborn be scored immediately after birth. The goal of the birth score is to ultimately reduce post-neonatal death.
- The Right From The Start Project, with its 233 trained nurses and social workers, care for pregnant and postpartum women and newborns and routinely discuss the need for correct sleep positioning as a means of reducing incidence of SIDS.
- The Office of Maternal and Child Health's Division of Research, Evaluation and Planning houses the State's SIDS Project. Since 1994, this entity has participated in the international *Back to Sleep* campaign through public lectures, literature and video distribution. As a public information effort, the Governor has annually declared October SIDS Awareness Month. The baseline in 1998 was 1.7 deaths per 1,000 live births.
- In FY 1999, 22 infant deaths were attributed to SIDS for a preliminary rate of 1.18 per 1,000 live births.
- Emergency medical personnel have been trained on strategies for assisting families with an infant loss

attributed to SIDS. This included face-to-face technical assistance of emergency room personnel at all the state's hospitals, provided in '99-2000 by the Provider Education team.

Outcome Measure 6: The child death rate per 100,000 children aged 1-14.

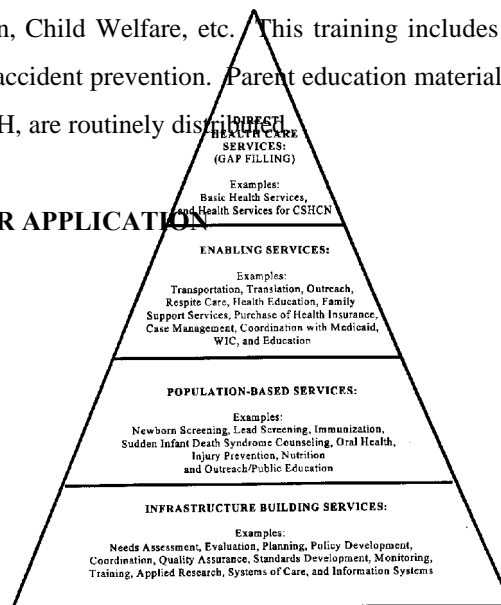
Outcome Objective: FY 1996: 28 per 100,000

Outcome Indicator: FY 1998: 21.8 per 100,000

Activities:

- Unintentional injuries remain the leading cause of death for ages 1 to 34 years. In 1998, motor vehicle fatalities included three children under age five years of age, the same as 1997. Motor vehicle deaths are down and continue to decrease since the passage of the seatbelt law in 1993.
- Through the EPSDT Program's Family Outreach Workers, the Pediatric Program provides anticipatory guidance on child injury (which might result in death) to all physicians and child care facilities in the State.
- RFTS personnel and all child service agencies distribute educational materials relative to reducing childhood injury safety tips to their clientele. CORE PUBLIC HEALTH SERVICES DELIVERED BY MCH AGENCIES
- MCH staff provide training for child care workers as a part of a skill building opportunity financed by the Department of Education, Child Welfare, etc. This training includes information on child safety, early detection of illness, and accident prevention. Parent education materials on accident prevention within the home, developed by MCH, are routinely distributed.

III REQUIREMENTS FOR APPLICATION



MCHB/HOSCH 10/26/97

3.1 Needs Assessment of the Maternal and Child Health Population

3.1.1 Needs Assessment Process

Introduction

This document is designed to meet requirements for the Title V needs assessment and subsequent state development of programs to meet the needs of women, infants, adolescents, and children, including those with special health care needs in West Virginia. The needs assessment reflects the perspective of families, private providers, and government agencies, since all are partners in assuring the effectiveness of the service system.

The planning process was coordinated by the Office of Maternal and Child Health (MCH), but multiple agencies were enlisted to ensure consumer input, and the non-biased collection of information. Multiple meetings of stakeholders were held throughout the state over a period of 15 months to solicit input. As a general rule, these meetings were conducted by persons not affiliated with MCH or the Bureau for Public Health. This structure was created by design to help assure a level of objectivity.

Essential MCH Functions	MCH Partnership Initiative
Strategic Planning	<ul style="list-style-type: none">• Public Health analysis of demographics, economic status, behavior, health status• Community perception of needs/health problems• Empowering and supporting stakeholders to convene
	Children's Specialty Care <ul style="list-style-type: none">• Commission for the Deaf and Hard of Hearing• Developmental Disabilities Council• WV Family Voices• Parent Empowerment Network• Let's Get A Life Project, including Teen Talk• Birth to Three Evaluation Task Force (Part C/IDEA)• Children's Specialty Care Advisory• Interagency Coordinating Council, Birth to Three• Fairshake Network

Essential MCH Functions	MCH Partnership Initiative
	Maternal and Child Health <ul style="list-style-type: none"> WV Dental Association Pediatric Medical Advisory WV Association of Community Health Centers WV Children's Oral Health Advisory Childhood Lead Poisoning Prevention Advisory WV Chapter AAP WV Chapter ACOG Perinatal Task Force Women's Health Advisory Adolescent Pregnancy Prevention Task Force SIDS Advisory WV Hospital Association Quota Club Association of Speech and Hearing Services Newborn Hearing Screening Advisory Breast & Cervical Cancer Screening Program Advisory WV Cancer Coalition WV University, Department of Pediatrics Government's Cabinet on Children and Families

	NEEDS ASSESSMENT PLAN DEVELOPMENT PARTNERS BY SERVICE COMPONENTS	
Perinatal and Women's Health	Children's Specialty Care (Part C IDEA/CSHCN)	Infrastructure

Objectives <ul style="list-style-type: none"> To develop a statewide needs assessment and plan reflective of the Healthy People 2010. To establish a formal process for input and guidance in the selection of goals toward stated objectives. To assure services purchased or provided by MCH Title are culturally competent. To assure access to health care for targeted populations (MCH) across West Virginia. 	Part C Lead Agencies	Pediatric Medical Advisory	Medical Advisory	Human Resources Investment Council
Perinatal Task Force	Governor's Cabinet on Children and Families	Developmental Disabilities Council		
Women's Services <ul style="list-style-type: none"> Medical Advisory 	West Virginia Kids Coalition	University Affiliated Center for Developmental Disabilities		
Association of Primary Care Centers	West Virginia CHIP	Let's Get A Life Project		
Association of Local Health Departments	Bureau for Children and Families (IVB/IVE, etc.)	Bureau for Medical Services		
WV Public Health Association	WV Dental Association	WV Speech and Language Association		
March of Dimes	Children's Oral Health Advisory	WV Commission for the Deaf and Hard of Hearing		
WV Cancer Coalition	SIDS Advisory	Family Voices		
BCCSP Medical Advisory	Childhood Lead Poisoning Prevention Advisory	Birth to Three Evaluation Task Force		
WVU Department of Pediatrics Birth Score & Genetics	Adolescent Pregnancy Prevention Task Force	Special Population Medley Class Members (De-institutionalized)		
WVU & Marshall Universities Department of OB-Gyn	Abstinence Only Education Advisory			

The Office of Maternal and Child Health checklist for process of community assessment and planning was multi-faceted and enabled health management in West Virginia to systematically involve and document community engagement in maternal and child health programs.

The Process

Surveys

Multiple surveys were used in the preparation of the Title V needs assessment:

- Family Planning: Contraceptives, Knowledge and Behavior
- Family Planning Outreach and Utilization Survey
- Obstetrical Patient Survey
- Pregnancy Risk Assessment Monitoring System
- Part C/IDEA - Family and Provider Surveys
- MCH/SSI Survey (Health Home)
- Developmental Disabilities Council Consumer Survey

Copies of all survey instruments appear as Supporting Documents, Section 5.3

Interviews/Public Forums

- Informal and formal interviews of children participating in adolescent health programs and specialty care services, including involvement in focus groups for assessing male adolescents in family planning services.

- Parent Empowerment Network, which is an organized network of parents in the disability community around issues of mutual concern. A primary focus of the network is to protect the rights of children with disabilities.
- The Deaf and Hard of Hearing Commission conducted hearings statewide to identify unmet needs and ascertain systems/services that are operational.
- Public meetings of parents and providers involved in Part C/IDEA were held throughout West Virginia. A total of 53 forums were held statewide.
- Perceived needs are the services people say they need. In order to gather information about perceived need, the Office of Maternal and Child Health contracted with the Office of Behavioral Health Services for focus groups involving consumers, providers of care, families and support persons for individuals with disabilities. Focus groups were held in locations that were wheelchair accessible throughout the state. The group developed a WV Self Determination Imperative document, see page number 80.
- Developmental Disabilities Council forums held simultaneous with the distribution of consumer surveys.
- To assure cultural competency, public interviews were held with significant/identified community leaders.

Analysis of Statistics and Records

- Gathering statistics on all aspects of the operation and analyzing findings was charged to the Bureau for Public Health, OMCH, Research Division and the Office of Epidemiology and Health Promotion, also within the Bureau for Public Health.

Specific Workgroups/Task Forces

- A Perinatal Health Committee was established to evaluate statistics, practice, referral patterns, etc. to make recommendations affecting mothers and newborns within the state.
- Children's Advisory developed the newborn hearing screening system, including care and follow-up protocols.
- The Let's Get A Life Project was funded in part by OMCH and overseen by the Office of Behavioral Health, Division of Developmental Disabilities, to obtain guidance from consumers and agencies.
- Children's Oral Health Assessment
- Birth to Three Part C Evaluation Task Force
- Adolescent Pregnancy Prevention Task Force
- Human Resources Investment Council (Workforce Investment)

As priority needs are identified, the State of West Virginia plans to use SSDI resources to continue

the engagement of community partners. The actual recommendations and findings will be taken by parent advisors employed under contract with the University Affiliated Programs (UAP), the Family Resource Networks (which serve as planning and administrative oversight forums in the counties), the Developmental Disabilities Council, and other consumer groups for development of action strategies to address needs.

While many of the needs are easily identifiable, such as smoking during pregnancy, access to medical care, self-determination and independent living, etc....actual “how to’s” about improving the system continues to require consumer-driven input and direction. A master listing of all data sources is contained in Section 5.3 as Appendix D.

Process Details:

A research study was initiated in May 1999 to obtain valuable information concerning contraceptive knowledge and behaviors of low-income West Virginia women, since nominal data is available in this area of women’s health care, particularly from the mid-Atlantic geographical region of the United States, from West Virginia, or from rural areas in general. In coordination with West Virginia University School of Medicine, Department of OB-GYN, the Family Planning Program completed data analysis activities. The objectives of the research project were multi-fold:

- To test knowledge about the effectiveness of various contraceptive methods in a defined population.
- To test beliefs about health risks and benefits of oral contraceptives in a defined population.
- To evaluate sexual behaviors, obstetric history, and reproductive health-related knowledge and attitudes about contraception and sexually transmitted diseases among Family Planning Program clients.
- To describe the relationship of self-esteem as it relates to women’s reproductive behaviors.

Final results of this study will be used for evaluation of knowledge and attitudes of clients enrolled in the West Virginia Family Planning Program, possible revisions to client education and counseling services provided within the Family Planning Program clinic network, and to guide a statewide outreach campaign intended to increase public awareness of family planning. The client education and counseling components of the Family Planning Program have been identified in past years as a potential area for improvement. This research project is viewed as a quality assurance/quality improvement process, to assess the general knowledge of enrolled clients in selected areas of reproductive health, to determine its impact on contraceptive decision-making, and to evaluate the effectiveness of current client education and counseling practices.

A. SURVEYS

Contraceptive Knowledge in Appalachia: A survey of 554 WV Women

Objectives: To evaluate contraceptive knowledge in a population of rural American women and to identify specific subgroups of women with significant knowledge deficits in an effort to provide clinicians

tools to target patients at higher risk.

Methods: Five hundred sixty-five women in family planning clinics across the State of West Virginia were surveyed regarding reproductive behaviors, contraceptive knowledge, demographics, and self-esteem.

Results: On average, women answered just more than 50% of questions correctly regarding failure rates, sexually transmitted disease protection, and risks and benefits of oral contraceptives. Women tended to underestimate efficacy of the both hormonal and barrier methods, possessed a fair understanding of few of the benefits of oral contraceptives and overestimated health risks. A very small but statistically significant relationship was found between knowledge and employment ($p = 0.03$, $r = 0.1$), formal education ($p = .0001$, $r = 0.26$), and self-esteem ($p = .001$, $r = 0.17$). No significant relationships were found between knowledge and age, race, marital status, or choice of contraceptive method.

Introduction

Currently in the United States, 90% of sexually active, fertile women who do not wish to become pregnant use a form of birth control, yet more than half of all pregnancies in the United States are accidental (1). The persistence of misinformation surrounding contraception worldwide has lead researchers to conclude that greater public education efforts are required of public health officials and women's health care providers (2-5). Contraceptive knowledge has been the topic of many studies in particular populations of American women over the past decade, notably college students, adolescents and navy personnel (6-9). None of these studies have focused on women residing in rural America, despite the fact that 24% of Americans inhabit rural areas (10). This important segment of women has geographically limited access to health care and education, and these women tend to be of lower socioeconomic status than women in the general population. This is especially true of women residing in Appalachia, which is particularly isolated both physically and culturally by its impenetrable mountains.

This study was designed for two specific purposes. First, we wished to evaluate the level of contraceptive knowledge in a population of predominantly low-income women residing in rural Appalachia. Our goal was to compare knowledge among these women to that previously found in other American populations, as well as to assess the effectiveness of education programs already mandated in the family planning clinics these women employ. Secondly, we sought to determine whether we could identify specific knowledge deficits and educational needs among specific subgroups of our subjects that would enable us to target future efforts to improve family planning literacy among women in the study region.

Materials and Methods

The target population for this study was comprised of low-income women (<250% FPL) ages 18-44 receiving annual contraceptive management services in Family Planning Program clinics in West Virginia. West Virginia lies wholly within the sociodemographic region designated as Appalachia. It has been estimated that 93,640 women in West Virginia are at risk of unintended pregnancy. "At risk" individuals are

defined as women in their reproductive years between the ages of 13-44, sexually active, and neither pregnant nor trying to become pregnant. This number includes 58,100 women age 20-44 and 35,540 female teens in West Virginia. The Family Planning Program provides services to a population of 75,000 unduplicated clients per year.

Women age 18 and older presenting to family planning clinics in WV for annual exams between June 1 and June 30, 1999 were eligible for the study. All clinics were operated by the WV Department of Health and Human Services. Clinic staff distributed surveys to 565 clients during registration or waiting periods prior to their appointment. Willing participants were given a packet containing the survey and a cover letter in which the voluntary nature of the survey and maintenance of anonymity were emphasized. Women were asked to complete the survey, place it in an unmarked envelope, and return the completed survey to their health care provider. Reading the cover letter with instructions and voluntarily completing the survey constituted informed consent.

Each participant completed a written questionnaire with 47 numbered items taking an average of 15-30 minutes. The questionnaire consisted of four parts. The first collected data on demographic characteristics including age, race, education, and marital status. The second part focused on sexual, contraceptive, and reproductive behaviors. The third section was a multiple choice test of contraceptive knowledge including failure rates of common contraceptive methods, efficacy of contraceptive methods in preventing sexually transmitted disease, and perceived risks and benefits of oral contraceptives. The final part of the survey was the 10-item Rosenberg self-esteem scale. The questionnaire, study design, and method of informed consent were approved by the Institutional Review Board at West Virginia University, see survey instrument, Appendix E.

Statistical analysis was performed after results were entered into a computerized database. CHI square and analysis of variance were utilized where appropriate.

Results

565 of the 800 surveys mailed were completed and returned before the June 30 deadline, constituting a 71% response rate. Eleven of the 565 were considered ineligible due to age less than 18 and were discarded, leaving 554 surveys suitable for analysis.

General Characteristics

Seventy-seven percent (77%) of the women studied were between 20-39 years of age. The predominance of Caucasian race (95% of subjects) reflected the racial composition of WV. Respondents were equally distributed between single women and married or divorced women. Most (82%) of the women had at least a high school diploma or equivalent, and almost half of those women had some college experience. A preponderance (387) of women reported using oral contraceptives. Other methods used included condoms (209), injection or Depo-Provera (68), withdrawal (37), sterilization (11), rhythm or natural family planning

(4), IUD (3), diaphragm (2), and Norplant (1).

Contraceptive Knowledge

Knowledge was assessed in three separate areas – failure rates of various contraceptive methods, contraceptive efficacy in prevention of sexually transmitted disease, and health risks and benefits of oral contraceptives. A “contraceptive knowledge score” was then calculated for each woman as a raw score of answers correct out of a possible 48. West Virginia women answered on average 57% of the questions correctly.

Perception of Failure Rates

Knowledge about contraceptive failure rates was assessed by comparing responses marked on a Likert scale with typical failure rates. Barely half (50.3%) of the respondents correctly estimated the efficacy of oral contraceptives; the majority of the remainder (46.7%) overestimated failure rate while a few underestimated failure rate (2.9%). Similar patterns were seen with the IUD, Norplant, and Depo-Provera, although a slightly larger percentage of women underestimated failure rates of Norplant and Depo-Provera (4.9% and 8.0% respectively).

A third of women (35.9%) correctly estimated the typical user failure rates of condoms, while almost half thought the failure rates to be higher than actual. A larger percentage (15.2%) of women underestimated the failure rate of condoms versus the hormonal methods. Overall, abstinence and sterilization were identified as the most effective methods of contraception. Greater than 50% felt that sterilization was 100% effective and failed to realize that there is potential failure.

Three hundred thirty-nine women responded that they had been pregnant at least once. Of these women, 39% reported using some form of birth control at the time of their first conception – 15% noted use of the pill, 10% were using condoms, and 10% used withdrawal. Few (<1%) also reported pregnancy while using diaphragms, rhythm method, and spermicides.

Perceptions of STD Protection

Knowledge of protection from sexually transmitted diseases provided by the various birth control methods was assessed by comparing responses on a Likert scale with the accepted values. More than half of the women (59%) cited the condom as providing “complete” or “quite a lot” of protection against STDs. The majority of women (72-92%) also reported little or no protection with the hormonal methods, IUD, sterilization, diaphragm, and no method. A notable percentage (16%) believed that abstinence did not provide complete protection against STDs.

Oral Contraceptive Risks and Benefits

Knowledge of the risks and benefits of oral contraceptive use was evaluated by multiple choice format questions..

The majority of women surveyed (74.3%) believed there are health risks associated with oral contraceptive use. The most commonly cited risks included weight gain, headaches, and blood clots. Many women also believed there were more severe risks such as breast cancer (27%), other cancers (23%), birth defects (22%), bleeding (27%), and stroke (21%). These perceptions of risk did not differ significantly between oral contraceptive users and non-users.

A similar number of women (72.2%) also believed oral contraceptive use provides health benefits. Most women noted regulation of periods as a health benefit. Other common answers included diminution of pain and bleeding. 24% were aware of the protective effects against ovarian cysts, 11% cited protection against certain types of cancer, 7% noted reduction in bone loss, and just 2% answered improved blood counts.

Contraceptive Knowledge in Relation to Subject Characteristics

A contraceptive knowledge score was calculated for each participant. The mean score of 27.48 out of a possible 48 correct responses with a standard deviation of 7.73 and range 13-48. Participants' scores were evaluated in relation to multiple variables including age, race, education, unemployment status, marital status, current contraceptive method, frequency of missed pills in pill users, and self-esteem. Few statistically significant relationships were found. The mean knowledge score of employed women was 27.68 versus 26.27 in unemployed women ($p = 0.03$, $r = 0.1$). A linear relationship was discovered between formal education and contraceptive knowledge. The mean score of women who did not have a high school degree was 24.54 and the mean score of college-educated women was 29.8 ($p = .0001$, $r = 0.26$). Pill users on average scored slightly higher with a mean of 27.99 versus 26.3 in non-pill users ($p = 0.018$, $r = 0.1$). Self-esteem was a small ($r = 0.17$) but statistically significant ($p = .0001$) determinant of contraceptive knowledge.

No significant relationship was found between knowledge and age, race, marital status, or choice of contraceptive method.

Discussion

West Virginia ranks second in the country in the provision of contraceptive services to women in need. The 136 publicly supported family planning clinics in WV serve 73,710 women. However, despite exceptional provision of services, 31% of births in WV are to unmarried women compared to the national average of 32%. The women surveyed exhibited distrust regarding contraceptive efficacy, misconceptions about contraceptive safety and benefits that are likely to impede the effectiveness of provision of contraceptive services. Our results point to the need for improved educational programs for family planning clients. Moreover, our results suggest that this need does not discriminate among women of different ages, educational attainment, or employment status.

Demographics in our study population differed only slightly than those reported in previous studies of women on college campuses (7, 8) and were very similar to women studied in the 1993 ACOG Gallup poll (11). Compared to women surveyed at Yale and Brown University, our respondents were somewhat less educated, racially homogenous (reflecting the Caucasian predominance in the distribution of this population in general), more likely to be married, more likely to be older, and more likely to use oral contraceptives.

Despite these differences, our women displayed knowledge deficits similar to these other populations. Our women answered just more than half of the questions correctly. Our subjects tended to underestimate efficacy of all methods except sterilization (Norplant>IUD>condom>ocps>depo>diaphragm). Compared to women studied at Brown University, the efficacy of oral contraceptives was less correctly estimated, and the effectiveness of barrier methods and spermicides was more correctly estimated (8). In the ACOG telephone survey, study participants exaggerated failure rates for all methods (see Figure 4) (11).

We speculate that the underestimation of oral contraceptive effectiveness in our population may be related to the high prevalence of oral contraceptive use at the time of conception of their first pregnancy were using oral contraception. Not only would such an experience affect the impression of effectiveness for the respondent, but perhaps for her family and friends as well. Such effects would have the effect of exaggerating the impression of method ineffectiveness in a population of contraceptors.

In addition to underestimating contraceptive effectiveness, women in our population harbored exaggerated concerns about adverse effects of oral contraceptives. Approximately one-fourth associated oral contraceptive use with severe disease such as birth defects, stroke, heart attack, and cancer. Use of oral contraceptives was not a determinant of these misconceptions, leading to concern for the internal conflict over well-being one can imagine for current pill users. Studies in other populations also revealed exaggeration of the health risks associated with oral contraceptive use and fears about safety, particularly pertaining to cancer (11). A study of men and women aged 18-44 in the U.S., Canada, and the Netherlands revealed that only

17% of Americans believe the pill is “very safe” (4).

Women in our study were generally aware of the health benefits of oral contraceptives relating to the menstrual cycle (i.e., pain, bleeding, and cycle regulation) but were much less aware of the protective effects against cancer, anemia, and ovarian cysts. Knowledge deficits regarding noncontraceptive benefits of the pill, as for exaggeration of risks, were not greater in our population than reported in other populations. Almost 50% of women in our survey incorrectly believed that oral contraceptives offered no health benefits other than pregnancy prevention, and in other studies educated women were found to be generally unaware that oral contraceptives have health benefits, including protective effects against ovarian and endometrial cancer, PID, benign breast disease, ovarian cysts, and ectopic pregnancies (7, 8, 11).

Our respondents for the most part were aware that condoms are the mainstay in prevention of sexually transmitted disease, and revealed similar knowledge in this area to respondents in the ACOG Gallup poll (11).

Comparatively low self-esteem and poor self-concept has been previously reported among adolescent females in Appalachia and other rural areas (12-14). The women in our study exhibited a profile of self-esteem similar to urban populations of women that have been studied. Prior studies in different populations have found a relationship of self-esteem with contraceptive knowledge among naval personnel and between knowledge and improved contraceptive use in adolescents (6) (15). However, other studies have proven no relationship and found self-esteem to be a poor predictor of contraceptive behavior in populations of adolescents and college women (16-18).

Lastly, we were unable to identify characteristics of contraceptors that predict their need for additional information. Although employed, more educated women with higher self esteem were more likely to exhibit slightly more accurate knowledge about family planning, differences between these women and others in our study population were small. This leads us to conclude that it is impossible to determine specific groups in greater need of education based on age, education, race, employment status, marital status, contraceptive method or self-esteem.

Survey: Patient Recruitment - Community Outreach, March 2000

The Problem: Since 1995, the total number of individuals served by our statewide Family Planning Program declined from 75,687 to 60,937 – a drop of 19.5%!

What this means: We, as a program, are failing to provide family planning services that are easily accessible and available when needed to the more than 34,000 West Virginians remaining at risk of unplanned pregnancy. Without prompt attention to this problem, the state’s rates of unintended pregnancy will increase, and there is even the potential for loss of future funding if our patient load continues to drop..

Survey Results

- More than half of the surveys have been returned. Surveys received represented at least one provider

in 47 of the state's 55 counties. Failing to respond were: providers in Ohio, Wetzel/Tyler, Pleasants, Roane, Calhoun, Upshur, Mingo and Monroe counties.

- The most often reported reason (N = 45) for a decrease in the number of family planning patients served was that potential patients are not aware of eligibility for services. Thirty-two respondents felt Medicaid managed care accounted for the decline.
- An overwhelming majority (N = 50) felt that clinics should increase the level of, or start, advertising their family planning services in newspapers followed by putting up posters (N = 34). Approximately one-third of respondents felt that radio advertising, exhibits and presentations could increase patient numbers.
- Two-thirds of respondents requested samples of newspaper ads and public service announcements followed closely by provision of posters. One-half would like brochures, and 23 felt that training on marketing services would be helpful.

In summary, the number-one reported reason for decline in patient numbers appears to be that potential patients are not aware of eligibility for services. Providers feel that advertising, especially in newspapers and with posters in public places would increase the number of people served. Additionally, they want our program to provide the tools to accomplish this: sample ads, posters, brochures and training in marketing.

A copy of the survey instrument appears as Appendix F.

The Office of Maternal and Child Health arranges obstetrical care for any woman who voices a need for service. However, we are most frequently called to assist persons who lack health care financing. In FY 1999, the OMCH surveyed obstetrical populations who had contact with MCH within a specified twelve month timeframe (July 1, 1998 to June 30, 1999). A summary of findings affirms Title V efforts to gap fill, by providing payment for obstetrical care for non-Medicaid eligible populations.

A copy of the survey with tallied responses appears as Appendix G/

West Virginia Developmental Disabilities Council

As an agency member of the West Virginia Developmental Disabilities Council, the Office of Maternal and Child Health participated in the development and distribution of a statewide needs survey circulated to more than 10,000 persons throughout West Virginia. Surveys were sent to key informants, including state and community program staff and managers, advocates, families, and consumers who are served by or work in the network.

For the purpose of the survey, the following definition of developmental disability was used. Also, the survey instrument and subsequent findings are referenced in the proceeding pages.

A developmental disability is a long-term disability that (1) occurs before a person reaches age twenty-two and (2) results in substantial limitations in at least three of the following areas: self-care, language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency. A number of different conditions can cause developmental disabilities. Examples include cerebral palsy, mental retardation, autism, epilepsy, and brain injuries.

The term may also be applied to infants and young children through age five who experience a significant delay or specific condition with a high probability of resulting in a developmental disability if services are not provided.

In addition to the survey, see Appendix H, public forums were held throughout the state, using an identified, non-government facilitator, see Appendix I.

WV Developmental Disabilities Council Survey and Plan Distribution

- **Statewide Needs Survey:**
 - Completed/Returned Council Office by June 25
 - Independent Tabulation/Summary Report by June 21 [Now July]
- **Regional Forums:**
 - **April 24** - Clarksburg
 - **May 1** - Huntington
 - **May 8** - Beckley
 - **May 15** - Elkins (Davis and Elkins College)
- **State Plan Draft and Distribution:**
 - Draft 3-Year Plan distributed to DDC members for review and comment by July 1;
 - Review/comments returned by July 10;
 - Revised Draft Plan distributed by July 17 to DDC members;
 - Final approval for three year plan at DD Council meeting on July 25
- **State Plan to ADD:**
 - Approved State Plan submitted to ADD by **August 10**;
 - ADD approval. Public version of plan published in **September-October**

Report Summary

The 2000 Year Developmental Disabilities Council Survey Findings:

1. Supports that enhance **self-determination** and **independent living** - transportation, accessibility, assistive technology, community awareness and financial stability;

2. **Medicaid Waivers/Medicaid services** in general - expanded benefits, more flexible eligibility and mechanisms to allow more choice and inclusion of oral health services;
3. **Employment Issues** - job development and skill training, issues with earnings and risk of losing benefits;
4. **Education** - teacher competence, supports (financial/training) for school system; and
5. **Home/Housing** - home ownership, accessibility, family support and respite, in-home supports and safety.

SSI Recipient Survey: Children's Specialty Care

The Office of Maternal and Child Health, Children's Specialty Care Division, obtained the names of current Medicaid/SSI recipients under the age of 16 years to survey with the primary question of ascertaining the impact of efforts to obtain medical homes for children with special needs. The survey was developed using SSDI resources and mailed in March 2000. Details of the survey, including the instrument appear as Appendix J.

West Virginia children receive their health care in private practice settings or at community health centers, although some do access family planning or dental care at a local health department. **Eighty-seven percent (87%)** of those responding to the survey were able to identify a health home.

B. PUBLIC FORUMS

- Male Involvement in Family Planning
- Birth to Three (Part C/IDEA) Provider and Public Forums
- WV Commission for the Deaf and Hard of Hearing
- Developmental Disabilities Council Public Forums

Purpose for Conducting Focus Groups for the State of West Virginia

A focus group is a group of interacting individuals having some common interest or characteristics. The individuals are brought together by a moderator. The moderator will in turn use the group and its interaction as a means of gaining information about a specific or focused issue.

Family Planning Focus groups were utilized as a tool in gaining the male perspective with regard to family planning in West Virginia. The information gained from the focus groups provided greater insight into what males in WV think about their role in family planning and what services they would like to see offered or improved upon. The discussions provided help in evaluating the existing family planning programs in the state and offered clues for developing strategies for outreach and increased male involvement.

Furthermore, the results of the focus groups will provide a representative sampling of the target population. The same principle has been successfully applied in other instances such as the Youth Risk Behavior Survey (YRBS) conducted by the West Virginia Department of Education. The 1999 YRBS has

demonstrated that there is still a high incidence of students engaging in risk-taking behaviors sexually (63.5 percent of WV high school seniors have had sexual intercourse, according to YRBS). Therefore, to effectively impact male youth and thereby reduce the likelihood of unplanned pregnancies, the male perspective must be identified and understood. Thus, conducting focus groups with WV male youth is clearly the most appropriate tool.

Focus Group Questions

1. What does family planning mean to you?
 - a) Where did you learn this information (first learned about information)?
2. If you have accessed family planning services what motivated you to do so.
 - a) To obtain contraception (condoms), STD testing, or information in general?
3. Where are these services located in your community?
4. What do you feel is the male role in family planning?
5. What issues do you think need to be addressed?
 - a) Health issues for men? Parenting issues?
6. Who should provide these services?
 - a) Male providers.
7. What pressures are on guys to be a father or not?
8. What roles do you think dads play in kids lives?
9. If unmarried what are advantages and disadvantages of becoming the legal father of one's baby?
10. If you were going to get more information about fathering or family planning, how would you like to get it: posters, brochures, videos, plays, peer teachers, speakers, and discussion?
11. Just how important are dads?
12. Have we missed anything? Any advice for us?

To safeguard, informed participation, we developed an informed consent document. The document is enclosed as Appendix K.

C. PUBLIC PROCESS: TOWN HALL MEETINGS

1. WV Commission for the Deaf and Hard of Hearing

The West Virginia Commission for the Deaf and Hard of Hearing (WVCDHH) serves as a communication bridge between hearing persons and those who are deaf or hard of hearing. WVCDHH strives to create an environment in which Deaf and Hard of Hearing West Virginians of all ages have equal opportunity to participate fully as active, responsible, productive, and independent citizens. To gather information about persons with hearing loss and to ensure close collaboration with the community, given MCH's assignment for early detection of hearing loss among newborns, WV's Office of MCH supported and attended Town Meetings throughout WV. The meetings were to determine unmet need.

Town Hall Meetings: WV Commission for the Deaf and Hard of Hearing

Meeting Dates and Locations

January 22, 2000	Glenville State College
March 3, 2000	Fairmont State College
March 7, 2000	West Virginia School for the Deaf and Blind
March 8, 2000	Martinsburg, DRS Facility
March 18, 2000	City of Parkersburg at Mayor's Office
March 30, 2000	Princeton DRS Facility
March 31, 2000	Lewisburg DRS Facility
April 1, 2000	Beckley Association of the Deaf
April 8, 2000	Huntington Association of the Deaf
May 6, 2000	Charleston Division of Rehabilitation Services Facility

Town Hall Flyers Distribution

Self-Help for Hard of Hearing	101
Galludet University Alumni	55
RESA	8
Hearing Aid Dealer	85
Deaf/Blind (Local)	6
Special Education Directors including WVSD's	56
Alexander Graham Bell Association	14
Birth to Three Provider	13
Independent Living Center	5
WV Assistive Technology Center	3
Domestic Violence Center	13
Speech-Language Pathologist/Audiologist	594
WV Deaf Club President	12
Mental Health Service Center	7
WVCDHH's mailing list (WVAD & Census, too)	@ 500
Department of Health and Human Resources	94
Senate and House of Delegates	134
Board Members of WVCDHH	15
Division of Rehabilitation Services	<u>11</u>
TOTAL Distribution of Flyers	1,726

Town Hall Meeting Information in Other Newsletters

WV Assistive Technology	6,000
WV Association of the Deaf	432
WV School for the Deaf Alumni Association	1,000
WV School for the Deaf "The Lions' Tale"	<u>200</u>
TOTAL Distribution	7,632

- Average Meeting Attendance - 37 persons.
- Participants:

Deaf	52%
Hard of Hearing	15%
Hearing	33%

In West Virginia, the availability of interpreter services was identified as a significant problem during the Town Hall Meetings.

Educational Interpretation in Public Schools 1999-2000		
Total	55	
Survey Mailing	55	
Counties with Interpreters	68% (33/55)	
Interpreters by Placement	58%	Elementary School
	21%	Middle School
	21%	High School
Certification	81%	No Certification
	15%	NAD Certification
	3%	Unknown
	1%	VQAS

Source: Advisory Council on Education for Exceptional Children and Town Meeting Input

Findings

39% of the state's counties do not have educational interpreter services available. As more children are assessed for hearing loss at time of birth, through EPSDT and other health services, there may be an increased demand for services. Because newborn hearing screening has only just been implemented, it is too soon to assess.

Town Hall Meetings Summary - Commission for the Deaf and Hard of Hearing

- **Four issue clusters have been identified for further attention to planning:**
 - < Educational Services for Interpreters
 - Education
 - Training Programs
 - Certification
 - < Technology
 - Emergency Response Systems
 - Disaster/Emergency Services
 - Broadcasting/Networking
 - Telecommunication Options (Access)
 - Relay Service/Public Service Commission
 - < Human Services
 - Creation of Satellite Offices (Advocacy and Outreach)
 - Public Transportation Access
 - Department of Transportation - Update of Guidelines
 - Access to Mental Health Programs
 - Access to Division of Rehabilitation Services – Vocational Rehabilitation
 - Access to Welfare Programs
 - Hospital/Medical Center Access
 - Law Enforcement
 - < Clearing House Responsibilities
 - Legislative Bills
 - Advocacy/Outreach - Community
 - Interpreter Directory
 - Interpreting Certification and Maintenance
 - Educator's Directory
 - ADA Training
 - Resources Directory
 - Community Collaboration
 - TTY Access in Public Places
 - Interagency Database Collaboration

2. **Teen Talk**

Questions were asked about how it feels to be a teenager with a physical disability. A number of different issues were touched on, including self image, independence, and advocacy.

- Speaking up for Myself
- Handling Unwanted Help
- Being Independent

The above are the most commonly identified problems voiced by teenagers with disabilities. Unfortunately, there are no programs targeted toward helping young persons with disabilities develop social competency, self-advocacy skills, etc....limited components are available, hidden within larger assignments.

Action: Contract with the Fair Shake Network to enable young people to participate in self-advocacy skill building opportunities. All MCH Specialty Care programs are charged with identification of potential participants.

3. **Investing in the Future: Economic Development**

Statewide Human Resource (Workforce) Investment Council was established in 1997, one full year before the passage of the Workforce Investment Act. The plan was for WV to be prepared for changes in the federally funded job training and employment program. Public forums were held in every region of the state to gather local input regarding the needs and approaches required for a more effective and efficient system of workforce development. A regional model was developed – five geographic areas closely aligned to economic development areas of the state. The model was presented to the public in another series of regional forums and modified as a result. Subsequently, the plan modified by local input was recommended to the Governor.

Recommendation was for a local workforce service delivery area to receive federal funding and support local activities. This plan was recognized by the federal Department of Labor and state government as a vehicle for maximum flexibility, while providing for a more efficient central administrative structure. Each region, working with the Governor's Workforce Investment Office, appointed local workforce investment boards to oversee the program. Extensive training and technical assistance has been provided to local elected officials and to the boards.

D. **SPECIAL WORKGROUPS/TASK FORCES**

- Perinatal Task Force
- Adolescent Pregnancy Prevention Task Force
- Children's Oral Health Advisory
- Birth to Three Evaluation Task Force (on-going)
- Let's Get A Life (Disability Focus)
- Workgroup: Assuring Cultural Competency

1. **Perinatal**

The WV Perinatal Task Force 2000 was established to recommend strategies for a perinatal health system that provides for accessible, appropriate services with the ultimate goal of improving the health status of mothers and infants. Preliminary recommendations are as follows:

- Smoking during pregnancy contributes to the incidence of low birthweight. Provide “start-up” packets of information about pregnancy that is distributed preconceptionally.
- Increase early enrollment of pregnant women into the WIC program.
- Increase the number of health education classes in schools that provide a parenting curriculum.
- Support and monitor WVDHHR provider recruitment efforts in an effort to increase access to prenatal care.
- Increase public awareness about SIDS.
- Increase efforts and attention given to enrolling newborns into health system financing, Medicaid, CHIP, etc.
- Plan a summit for fall 2000 to discuss low birthweight and develop further action strategies.

Assessment of Needs for Services to Prevent Low Birthweight

Standard	Specific Agencies/Organizations					
	School System	Community Centers	Private Practitioners	Community Agencies Health/Social Services	State Agency MCH DHHR	Local Health Departments
Family life and sex education in health curriculum in grades K-12.	X					
Prenatal Care education in private practitioners' offices, community health clinics, local health departments	X	X	X	X		X
Toll free lines, offering service coordination for medical, financial and social support – Resource Directory				X	X	
Prenatal care provided in partnership with providers statewide.		X	X			X (2)
Transportation (special financial support under ART)		X	X	X		X
Individual counseling about prenatal care at time of pregnancy testing.		X	X			X
Regular home visits by trained nurses and social workers.		X	X	X		

Standard	Specific Agencies/Organizations					
	School System	Community Centers	Private Practitioners	Community Agencies Health/Social Services	State Agency MCH DHHR	Local Health Departments
Linkage with health and social services supports.	X	X	X	X	X	X
Individual counseling and assistance to remain in school.	X	X		X		
Confidential pregnancy testing and counseling.		X				X
Community outreach and follow-up.		X	X	X	X	
Risk-appropriate prenatal care.		X	X		X	X
Age appropriate preconception care and counseling.		X	X	X	X	X
Education about smoking and drug use during pregnancy.	X	X	X	X	X	X
Assistance with food stamp application.		X		X	X	X
Active promotion of WIC enrollment.		X	X	X	X	X

Legend: Standards represent the services that should be available to address the precursors of a (health) problem. Standards were derived from professional judgement and the development of consensus among task force/forum attendees, etc.

WVDHHR/BPH/OMCH/WS./Perinatal Task Force/02-00

2. Adolescent Health: Teen Pregnancy Prevention Task Force

Adolescents and unintended pregnancies have devastating consequences.

Healthy People 2010 Objective 5.2

Reduce to more than 30 percent the proportion of all pregnancies that are unintended.

- Efforts should be made to encourage teenagers to postpone sexual activity including the following:
 - Abstinence education activities should be continued.
 - Risk resiliency/decision-making skills must be available throughout WV.
- Sexually active adolescents must learn the facts about birth control and use it consistently.
 - Increase public awareness about the availability of free contraceptive care to persons with income at or below 100% FPL, and the reduced service cost for those at higher income levels.
 - Assure that all school-based health sites are affiliated with community-based family planning sites for adolescent referral.
 - Develop a campaign to promote the responsible use of contraception by those

teenagers who are sexually active. (This fits into growing efforts to reach males, and to teach that family planning is not a female issue.)

- Recently, seventh and eighth grade girls from the Charleston area were asked why teens become pregnant. Here's what they said:
 - They think it would be fun.
 - Everybody is having sex; so they go out to have sex too.
 - They want someone to love them back.
 - It makes them look mature – older.
 - They get lots of attention, when they bring babies to school, everyone crowds around them.
 - They want to fit in.
 - They think they are in love, cool, and mature.
 - They watch too many television shows.
 - People put a lot of pressure on them.
 - They are scared to use birth control because they are afraid their parents will find out they're having sex.
 - Birth control pills make you sick.
 - They think it "can't happen to them."
 - Sometimes they are forced into it by an older person. My friend is 14 and shew as with a 40 year old guy. Her mom doesn't give her much attention.
 - Some parents think they are saying it's o.k. to have sex if they are putting their daughters on birth control; like they are giving permission and they don't want to do that.
- The information, obtained from WV teenagers living in the Charleston area, has been distributed in a statewide newsletter, "News to Use," prepared and distributed by the Adolescent Health Coordinator serving Region I.

3. **Oral Health**

Description of Need/Problem, Recommended by Children's Oral Health Advisory

Dental health utilization among WV children is poor, even for those with financing.

Healthy People 2010

Increase to at least 50% the proportion of children who have used protective sealants on the chewing surface of permanent molar teeth.

- Lack of education and awareness about the need for oral health care.
- Maldistribution and/or lack of availability of dental practitioners.

- Lack of parental guidance and mentoring of a positive health behavior skill. Adults (especially low income, disabled adults) do not have access to financing for oral health care.

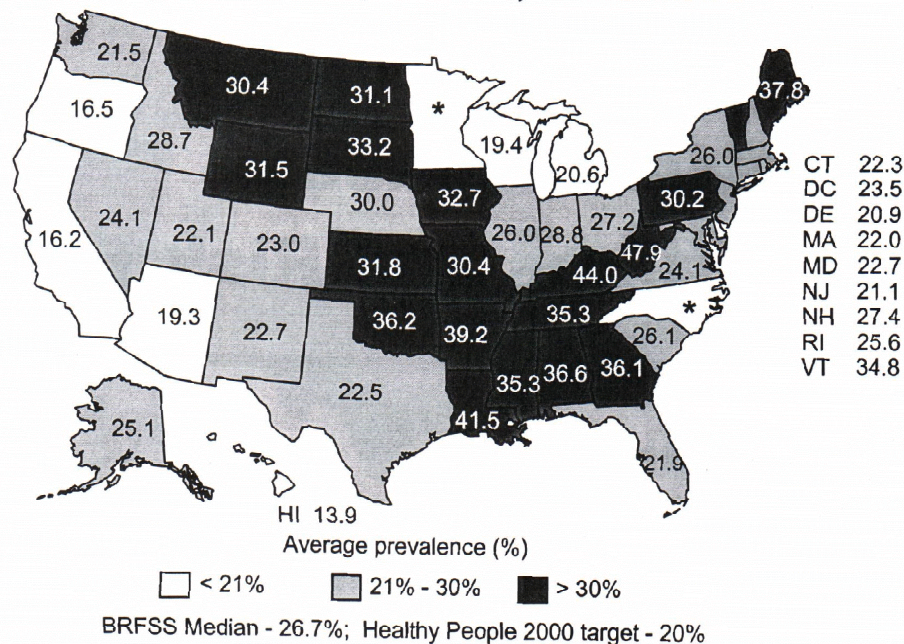
Disabled and Vulnerable Adults

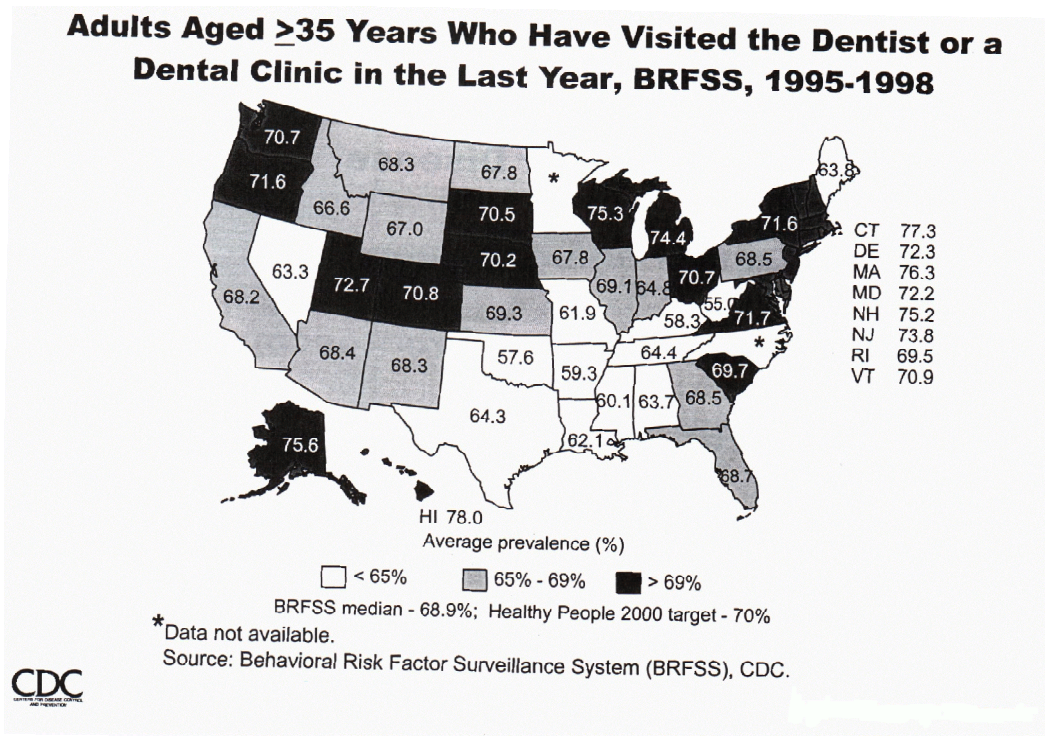
Poor and near poor adults are less likely to receive dental care. In WV, disabled adults, including young persons transitioning from Children with Special Health Care Needs because of age, who are recipients of Supplemental Security Income, do not have access to financing dental health. The WV Medicaid program does not include dental coverage for adults regardless; consequently, low income, disabled adult populations have no coverage for this service.

Survey and public information gathering forums have identified dental health as a significant unmet need. This includes a survey of unmet need among a special population group with developmental disabilities who have relocated from mental health hospitals to individual appropriate community settings. This survey, which cites dental health as the most pressing unmet need is listed as Appendix L.

The West Virginia Dental Association and the Foundation of Dentistry for the Handicapped, an affiliate of the American Dental Association whose main office is located in Colorado, have joined with the WV Department of Health and Human Resources to start a Donated Dental Services Project in our state. The Project will recruit volunteer dentists to donate more than \$50,000 in free treatment to 50 people with disabilities and/or elderly in West Virginia. This makes WV one of 26 Donated Dental Service projects throughout the nation. To ensure coordination and collaboration, the Department of Health and Human Resources is working alongside the Developmental Disabilities Council, West Virginia Advocates, and the Bureau for Senior Services.

Adults Aged ≥65 Years Who Have Lost All Natural Teeth, BRFSS, 1995-1998





The Children's Dental Health Task Force was formed to conduct a comprehensive analysis of oral health care access. The study was to include an inventory of existing service delivery programs and sites, and the supply and distribution of primary oral health care providers. The task force was also charged with developing recommendations. The Task Force was multi-disciplinary and representative of both the public and private sector providing dental services across West Virginia, including state government, professional associations, community health, etc.

Data Collection and Analysis - 1997-1999

This phase involved:

- health professional survey conducted by the OMCH Children's Dentistry Project;
- identification, collection and analysis of data on publicly funded dental services;
- an inventory and assessment of health professional supply and distribution; and
- oral health needs assessment of WV's school-aged children.

Process

The Office of Maternal and Child Health surveyed all licensed practicing dentists in 1997-98 to determine their willingness to care for government-sponsored children (Medicaid and CHIP). We also asked the question, "if unwilling to serve this population, why not?"

Dental care is an optional Medicaid service for adults and a mandated service within the comprehensive Early and Periodic Screening, Diagnosis and Treatment Program for children. Recent Health Care Financing Agency (HCFA) data showed that only 1 in 5 eligible Medicaid children receives preventive dental services. A review of dental care utilization among West Virginians is equally bleak..

West Virginia children with Medicaid or CHIP have an adequate dental package, but only 65% of West Virginia dentists provide any type of services to Medicaid children, as extrapolated from our survey.

Inadequate reimbursement, administrative burden, and delays in reimbursement were the most frequently cited reason for non-acceptance of Medicaid sponsored children for dental care in the health professional survey conducted in 1998.

Private dentists on the Children's Oral Health Advisory (OMCH) and interviews among community dentists report significant administrative issues, such as pre-authorization requirement, under Medicaid, which delay care, require more time, are also contributing factors to the overall lack of attention to Medicaid children.

Regardless, if the state can, or wishes to tackle the above issues, it will require attention to increasing parent and child knowledge about dental diseases and the importance of the appropriate use of dental services.

Further Recommendations

- Incorporate preventive dental education and referral in perinatal program encounters (Right From The Start), WIC encounters, and early child development and education programs serving children and toddlers.
- Implement more prevention and education programs in child care facilities and schools.
- Develop school system education, prevention and intervention initiatives using dental hygienists as the educators.
- Coordinate and require curriculum in medical professional schools, to assure oral health is addressed as a component of comprehensive care.
- Educate West Virginia residents as to the appropriateness of fluoridation of all community/public water sources.
- Explore the expansion of loan repayment programs to create incentives for dentists to work in rural areas. Consider an expanded role within the Office of Community and Rural Health Services - Division of Primary Care to address rural recruitment strategies specific to dentistry.
- Streamline Medicaid administrative requirements.
- Explore Medicaid coverage for adults, especially those with disabilities receiving SSI, see Specialty Care component of the needs assessment.
- Expand Medicaid reimbursement.

Disability Community: Children with Special Health Care Needs

4. Birth to Three (Part C/IDEA) Evaluation Process

The Birth to Three Task Force is a broad-based stakeholder group with geographic and racial/ethnic representation, as well as a variety of stakeholders including key agency decision makers, local program administrators, practitioners, and family members. Persons selected for Task Force participation are those who can speak for their constituents and who serve as a leadership voice with them, as well. A participation selection chart was prepared that divides people by geography, discipline or constituent voice, race, ethnicity, etc. and used to identify where representation is secure, where individuals can assume more than one “voice,” and to assure there is balance in the membership. The following is the timeline of activities for the Task Force.

Summary of Existing Information, Data and System Materials

Preparation of a summary of the “status” of Part C in West Virginia focusing on the key outcomes that were identified by stakeholders. Task Force will review a variety of materials in the development of this product. *Target Date for Completion: September 1999.*

Regional Profiles (to present a variety of extant data)

Collect and organize a variety of data that will assist the Task Force to assess the effectiveness of the WV Part C system, and to plan for intervention strategies that are based upon local need and potential prevalence. Data was initially gathered by county and organized according to the 12 jurisdictions. The profile development and publication included one (1) camera ready copy for use in reproduction and distribution, a copy each for the Task Force members and key state officials. *Target Date for Completion: September 1999.*

IFSP Survey: Methodology and Findings

Process was to collect and analyze a 25% sample of Individual Family Service Plans (IFSP). These data help us to develop a variety of data including average age of referral, service portraits by region/disability/age, and include some compliance measurements. IFSP sampling was drawn from children enrolled, with active IFSPs as of December 1, 1998. *Target Date for IFSP Sampling: July 1999*

Time Study Methodology and Findings

Collection of a two or four week time sample that asks individuals how they spend their work time, in 15 minute increments. There are several activity centers that people use to record this information including direct service as well as time spent on administrative activities, travel, etc. Time study was completed on 100% of local agency program staff.

This time study activity helps us to identify where and how people are using their time, but also illustrates their productivity which is invaluable when we start talking about rates, training and personnel capacity. A variety of practitioners were in the sampling including service coordinators. *Target Date for Time Study: October 1999*

Service Coordinator and Service Provider Survey Methodology and Findings

Family Survey Methodology and Findings

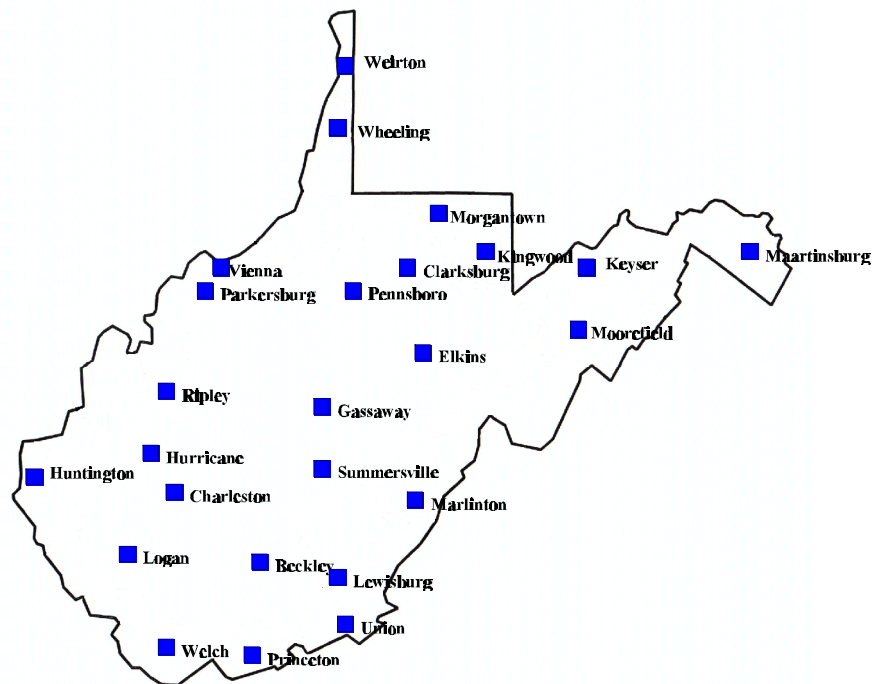
Local Network and Other Community Council Survey Methodology and Findings

Surveys were used to obtain perception, experience and recommendations for change from a variety of stakeholders. *Target Date for Survey Activity: Survey activities were conducted in May 2000. Data analysis activities and report development was in June 2000.*

Provider Forums Outcomes/Family Forums Outcomes

Key locations throughout the state were identified and separate parent and provider forums were held. Counties/communities within each of the regions were site location, that together reflect the diversity and demographics of West Virginia. The purpose of the Forums was to present the findings from the IFSP review and surveys, together with the direction/thoughts of the Task Force specific to preliminary evaluation outcomes and/or redesign thoughts for the EI system. *Target Date for Forums: May 2000, see map below.*

Birth to Three Family Forum Sites



Interagency Data System Evaluation

Review of the current Birth to Three data system, as well as other existing data bases to determine linking capability (e.g., Medicaid) and provision of recommendations to support Birth to Three data needs as well as those within the field, linkages to financing, forecasting, etc. *Target Date: June 2000*

Current Resource Allocation and Availability: Fund Utilization and Expansion Recommendations

Through IFSP sampling, interviews and data collection, we assembled a portrait of funding for services in the system. The data gained through the time studies were incorporated into the analysis and used to direct training and other administrative recommendations. Ultimately, this information will serve to improve the productivity of personnel, which has direct implications upon the effective use of resources.

An additional activity under this financial component was the review fund applicability and potential new resources to support the state's Part C system. *Target Date: June 2000*

State Agency/Key Stakeholder Interviews

These interviews served as both an opportunity to obtain information and perspective from key individuals throughout the interagency system, as well as provide an opportunity for gradual information and stakeholder support development. *Target Date: Ongoing*

Summary of Data Needs, Approaches and Options with Recommendations

The summary of findings gradually unfolds throughout the course of the project and the Task Force is largely responsible for hearing these findings and recommendations from the consultants and moving to develop their own recommendations to the lead agency. *Target Date: July 2000*

Preliminary Task Force findings and recommendations will be distributed September 2000.

5. Let's Get a Life Project

Let's Get A Life Project works with communities/providers to discuss needs, identify community-based service availability; seek consumer input to evaluate whether identified services and support meet the needs of persons who are likely to require assistance in order to live in the community. Government, as a partner, will use the information to assess the extent to which funding sources can be organized into a coherent system to meet the needs of consumers with disabilities. The Project will:

- Bring a broad group of individuals, family members and agencies together to develop a comprehensive family support self-determination vision.
- Train, advocate and serve individuals and families in self-determination of community-based services leading to independence.
- Monitor and evaluate residential, employment, recreational, respite and other systems issues as they relate to quality care in the community.
- Implement two demonstration flexible funding programs for families and individuals.

Perceived needs are the services people say they need. In order to gather information about perceived need, the Office of Maternal and Child Health contracted with the Office of Behavioral Health Services for focus groups involving consumers, providers of care, families and support persons for individuals with disabilities. Focus groups were held in locations that were wheelchair accessible throughout the state.

FINDINGS OF THE PROJECT: LET'S GET A LIFE

Access/Mobility

ISSUE	PERCEPTION	PREVALENCE DATA
Architectural Design of Public Buildings	9	76.6%
Lack of curb-breaks in incorporated cities.	10	89%
Limited access to recreation facilities.	10	57.8%

Legend: Ranking from 1 to 10, with 10 indicating highest ranking problem.

Action: This group has enjoined with the State Developmental Disabilities Council to boycott a frequently used meeting site which did not met ADA standards,

Contracted with Mountain State Center for Independent Living to determine the actual number of cities without sidewalk/curb breaks. Individuals with disabilities who reside in the affected cities have received charge to speak before City Council to resolve the issue.

Worked with the West Virginia Development Office reviewing parks and other facilities to assure accommodations are handicap accessible.

Inability to Achieve Independence

ISSUE	PERCEPTION Adult Persons with Disabilities	PREVALENCE DATA
Limited Employment Opportunities	10	83%
Public Policy**	8	69%
Self Determination***	10	91%

Legend: Ranking from 1 to 10, with 10 indicating highest ranking problem.

** Social Security Administration penalizes a person receiving Supplemental Disability Insurance (SSI) from partnering/marrying a non-disabled person. The policy is that should these two people marry, their joint income affects the SSI recipient's eligibility. This is a significant threat for persons dependent on the SSI triggered Medicaid card for coverage of medications, and other health services.

*** The ability for individuals, with freely chosen family and/or friends, to plan a life with necessary support other than a "purchase program;" i.e., this is in response to the Medicaid Waiver Program.

6. **Summary of Public Discussion Related to Self-Determination and the MR/DD Waiver**

Expand the use of the MR/DD Waiver Program **while reducing** the use of other, less appropriate Medicaid services (ICF/MR, Clinic, Personal Care, Rehabilitation, nursing home care).

- Use the most inclusive interpretation of **eligibility** standards sanctioned in the U.S.
- Proceed to **close ICF/MR group homes** while relocating people into 3 bed or less sized housing that is typical for their communities.
- **Stop funding** services in residential settings of 4 beds and larger in size.
- Give all persons who would be eligible for the MR/DD Waiver who is served through the State Plan services, ICF/MR, State Long Term Care Facility, nursing homes and the Aged and Disabled Waiver the **option of enrolling** in the MR/DD Waiver.

Expand **respite care** and other supports to families of children and adults who wish to live with their families.

- Permit families to use a **budgeted amount of money** for a set period of time (e.g., a month) and pay a rate necessary to secure the respite care services that serves their family member. Permit unused monthly balances to be carried forward for two months. Permit remaining balances to be put into a **pool** for all families to access for emergencies.

Promote **employment** and appropriate volunteerism for people and make **day services more meaningful** for their participants (truly focused on developing self sufficiency and empowerment).

- Put in place **incentives** for people receiving true community based experiences. Radically reduce the reimbursement rates for facility based services.

Better serve **seniors** who have developmental disabilities.

Simplify certain service delivery and record keeping.

- **Replace cumbersome** quarter hour, half hour and hourly **units of services** with per diem payments where possible (e.g. case management, specialized care home and natural family home habilitation).
- Focus on **performance indicators** rather than time.

Move to more **person-directed** supports.

- Develop **fiscal intermediate agencies** that would offer a range of administrative and fiscal services to participants including the management of payroll, taxes, etc. for persons employed to provide personal assistance services.
- Make the MR/DD Waiver “package” more **complete and flexible** for persons (include home modifications, skilled nursing, personal assistance, etc.).
- Teach participants and their families how to effectively **direct their own services and supports** (including case management functions, respite care, supported employment,

personal assistance).

Provide reasonable, accessible and efficient **due process** procedures available.

Make the use of the resource more **accountable and cost effective**.

- On a regular basis provide to individuals or their guardians printouts of the services received and charges billed by the various providers. *Families want more persons served well. (This includes **spending less** on behalf of their family members when the money is spent on programs, evaluations and services they do not see as beneficial to the individuals.)*
- Include (and financially support) self-advocates who have disabilities and family members of persons supported with Waiver resources in the **monitoring** of providers.
- Encourage **competition** among the providers (including the support to new, qualified providers).
- Assure that new funds for **expansion** (reportedly \$5 million) are used to serve more people in need.

Move to a structure of broad supports (rather than numerous discrete services) with a flexible budgeting approach such that an individual's supports are driven by a person-centered planning process.

West Virginia Self-Determination Imperative

We the undersigned members of the West Virginia disability community believe the following principles must be followed in order for freedom and choice to be realized by all people.

In the domain of Human Rights:

All people have fundamental moral and constitutional rights.

These rights must not be abrogated merely because a person has a mental or physical disability.

Among these fundamental rights is the right to live in the community of their choice.

To pursue the Vocational/Educational goal which is consistent with their talents and preferences. To be free to engage in a full range of activities across their life span including, but not limited to: school, competitive employment, parenting and retirement. Individuals must be allowed maximum control of their available resources in order to live-out their dreams to the fullest extent.

We all have the right to self-determination.

As human beings we are all inherently valuable.

All people can grow and develop.

All people are entitled to conditions which foster their development.

Such conditions are optimally provided in community settings which are controlled and determined by the individual.

Signed

Date

Let's Get a Life Project - OBHS - WVDHHR

Assuring Cultural Competency

West Virginia's efforts on diversity were highlighted at the Annual Association of Maternal and Child Health Programs meeting March 2000, see Supporting Documents, Section 5.3, Appendix M.

7. Process

Organization/Administrative Review

Seek input from representative workgroup, comprised of consumers, agencies, providers, advocates, grantees, etc. by establishing ongoing formal and recognized mechanism to develop a master plan to increase awareness and improve cultural competency in WV.

Workgroup members were initially provided MCH information, including previous block grant materials, county profiles, economic and population data provided by the Office of Economic Development to enable participants to identify areas for improvement opportunity. A subgroup was also asked to review health service policies/mechanisms for customer feedback around the organizational mission statement and actions to assure commitment to principles of cultural competency.

The Concept

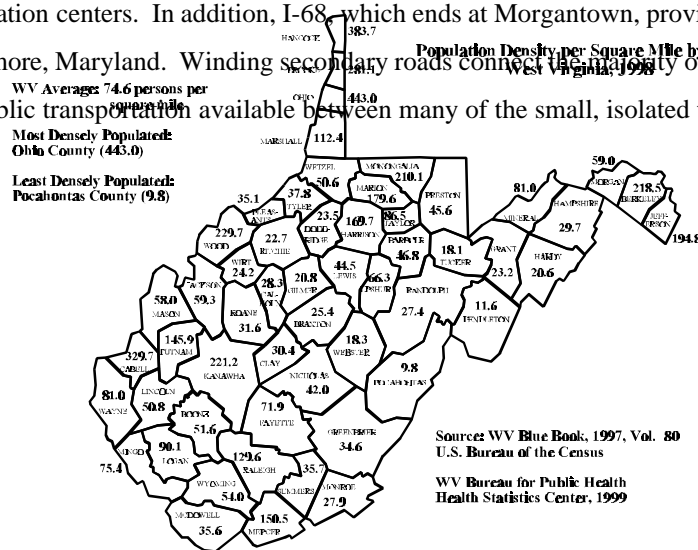
"Cultural competency is defined as a set of values, behaviors, attitudes and practice within a system, organization, program or among individuals which enable them to work effectively. It further refers to the ability to honor and respect the beliefs, language, interpersonal styles and behaviors of individuals and families and the person providing the services," modified definition, source, MCH Bureau.

Public Health staffers at the local level and providers of actual care were surveyed using the Georgetown University Child Development Center - UAP instrument with modifications.

As a result of survey/information gathering and the administrative review group, the following commitment to action occurred:

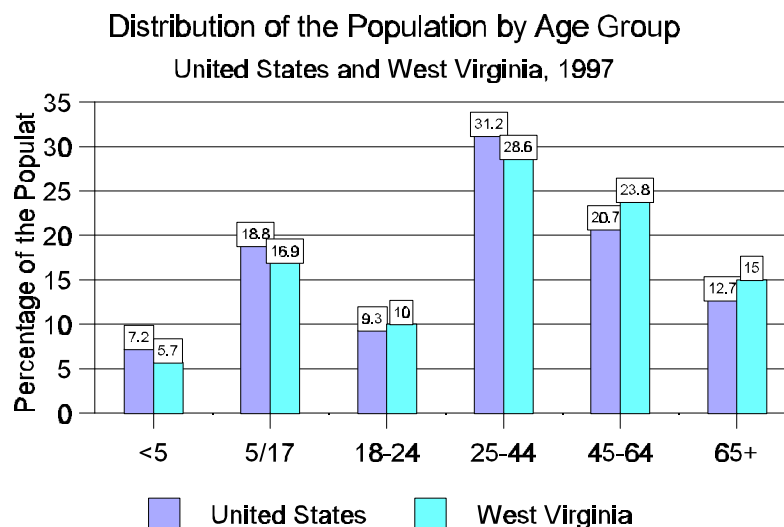
- Patient education materials, such as videos and brochures are reviewed by a committee, including consumers, to ensure that they reflect the culture of the state's population and reading competency levels.
- Alternative formats and accommodations are routinely available as needed. For example, training and public meetings have benefit of interpreter services.
- We will seek information from consumer and community members to assist on service and policy direction. Families have representation through a formalized network of Parent/Family Advisors who are employed by the UAP under a special grant. This was a deliberate action on the part of WVMCH to ensure the parent/consumer voice – and the uninhibited opportunity to speak freely.
- MCH policy is to hire from the community to ensure cultural competency and respect for the local area. This is reflected in the twenty-five year commitment to hiring home visiting

- Continue the MCH commitment to the purchase of posters and brochures that reflect cultural and ethnic diversity. A specific example is the continued support for non-English speaking migrant populations who influx to the Eastern Panhandle.
- Contract with the UAP to ensure that cultural diversity is addressed in medical education programming.
- Identified black churches, obtained support for breast and cervical cancer screening, with screening activities to occur on-site. This included identification of a person to champion from the community – a person to encourage targeted populations to seek services.



Population Trends and Characteristics: West Virginia's population reached its peak a half century ago, when 2,005,552 residents were counted in the 1950 census. The state's population has not exceeded the two million mark since then, but has fluctuated between 1.7 and 1.9 million depending on the state's economy. The estimated 1998 state population was 1,811,156, with a population density of 74.6 persons per square mile (see map). Compared to an estimated 8.7% increase in the national population between 1990 and 1998, West Virginia's population grew only 1.0% during the same time period. Four of the state's five largest cities have lost population since 1990. Charleston, the state capital and largest city, and Huntington are the only municipalities with populations exceeding 50,000.

The 1998 Statistical Abstract of the United States identifies four metropolitan statistical areas (MSAs) in West Virginia: Charleston, Huntington-Ashland, Parkersburg-Marietta, and Wheeling. To qualify as an MSA, the area must have one city with 50,000 or more residents, or a Census-Bureau-defined urbanized area of at least 50,000 residents and a total metropolitan population of at least 100,000.



Source: WV Bureau for Public Health - Health Statistics Center - 1998

West Virginia is among the most racially homogenous states in the country. The 1990 census reported that 96.2% of the residents were white, with African-Americans accounting for 3.1% of the population, Asian/Pacific Islanders for 0.4% and other races for 0.2%. These proportions are not expected to show significant change in the 2000 census count.

Composition of the state's population by age has changed markedly during the last half of the century, and West Virginia now has the oldest median age in the nation (38.1 years), surpassing even that of Florida (38.0). The aging of the state was illustrated graphically in 1997 when West Virginia saw its first natural population *decrease*, having had 137 more deaths in that year than births, the first state in the nation to experience such a phenomenon. The preceding graph presents the distribution by age group of the 1997

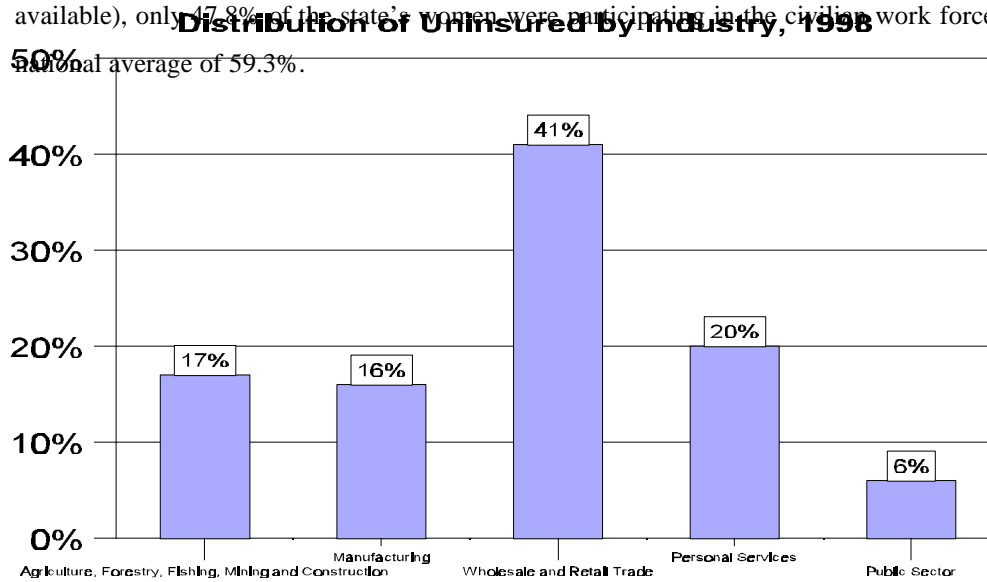
estimated populations of the state and the nation. As the graph shows, the older age groups compose a larger percentage of the population in West Virginia than in the U.S. as a whole. Because of its older population, West Virginia ranked 1st among the states in 1998 in the percentage of its residents enrolled in Medicare (18.4%, compared to a national average of 13.9%).

Employment and Labor Force: The table below illustrates the shift in the state's major employment industries over the past 30 years. As indicated, the dominant industries in West Virginia have shifted from mining and manufacturing to services and service producing jobs. Traditionally, mining and manufacturing wage scales are much higher than those in service occupations and include benefits such as medical, dental, and vision plans. Service jobs, on the other hand, are frequently part-time and usually do not include insurance plans. The low wages earned at such jobs often are not sufficient to allow individuals to purchase their own health insurance coverage.

West Virginia Employment by Industry (Non-Farm)				
Annual Averages (In Thousands)				
Industry	1998	1988	1978	1968
Total Non-farm Payroll	718.5	609.8	633.1	508.4
Private Sector	578.1	480.5	512.8	413.5
Goods Producing	140.4	145.9	227.0	203.9
All Mining	23.5	34.6	56.7	45.5
Coal Mining	18.7	29.4	51.6	40.7
Construction	34.5	24.3	43.7	26.0
Manufacturing	82.4	87.0	126.6	132.4
Service Producing	578.2	463.9	406.2	304.5
Transportation & Public Utilities	38.9	36.6	40.2	41.3
Trade	163.2	142.7	131.8	90.8
Finance, Insurance, & Real Estate	28.6	24.3	21.2	14.7
Services	207.0	131.1	92.7	62.8
Government	140.5	129.3	120.3	94.9
Source: West Virginia Bureau of Employment Programs, 1999				

According to figures provided by the U.S. Department of Labor, Bureau of Labor Statistics, state unemployment stood at 6.6% in 1998, the highest of the 50 states and exceeded only by the District of Columbia. The national average in that year was 4.5%. Of all the states, West Virginia has the lowest

percentage of women participating in the labor force. In 1997 (the most recent year for which data are available), only 47.8% of the state's women were participating in the civilian work force, compared to a national average of 59.3%.



Source: Employee Benefit Research Institute estimates based on the March 1999 Current Population Survey

Kaiser Commission on Medicaid and the Uninsured

Work disability is a significant problem in West Virginia. In 1990, 12.6% of the labor force had a work disability, and 8.4% were prevented from working at all due to a work disability. The latter figure is twice as high as that for the United States as a whole and the highest among the states.

Income and Education Statistics: U.S. Bureau of the Census figures place West Virginia 51st among the 50 states and the District of Columbia in median household income, using a three-year average of data from 1994-96. The state's median household income for those years was \$26,505, compared to a national median of \$36,399. The state's per capita personal income for 1997 was \$18,718 compared to \$25,298 for the United States. The map below depicts the average per capita income by county for 1997, which ranged from a high of \$24,435 in Kanawha County to a low of \$12,128 in Webster County.

As noted previously, there has been a dramatic decrease in high-paying mining and manufacturing jobs in West Virginia over the past 30 years, with a concurrent rise in the state's poverty rate. According to figures supplied by the U.S. Census Bureau and reported in *State Rankings 1999* (published by Morgan Quitno), in 1997 West Virginia ranked 5th in the nation in the percentage of its population living below the

poverty line. Using a three-year average of data from 1995-97, 17.2% of the state's residents were living in poverty, compared to a national average of 13.6%.

The economic and health care costs of educational dropouts place an incalculable burden upon an area's economy. Individuals lacking a high school diploma have difficulty finding jobs that pay more than minimum wage and provide health insurance.

Population Characteristics: From 1990 to 1998, West Virginia's population increased by 1 percent, a figure lagging far behind the national growth rate of 8.7 percent, but an improvement from the 8% loss during the 1980's. Likewise, the state experienced positive net immigration, reflecting improved economic conditions.

The eastern panhandle counties (Morgan, Berkeley, Jefferson, Hampshire, and Pendleton Counties) and suburban counties border Cabell, Kanawha, and Wood Counties (Putnam, Jackson and Wirt) experienced the greatest population gains, while the greatest population losses occurred in the southern coalfields and the metropolitan core counties, particularly in the Northern Panhandle.

West Virginia's population is aging rapidly. Nearly all population gains occurred in the 35+ age groups, with the greatest gains occurring in the 45-54, 55-59 and 75+ age groups. Age groups 34 and under experienced population losses. West Virginia had the nation's highest median age as of July 1, 1998 at 38.6.

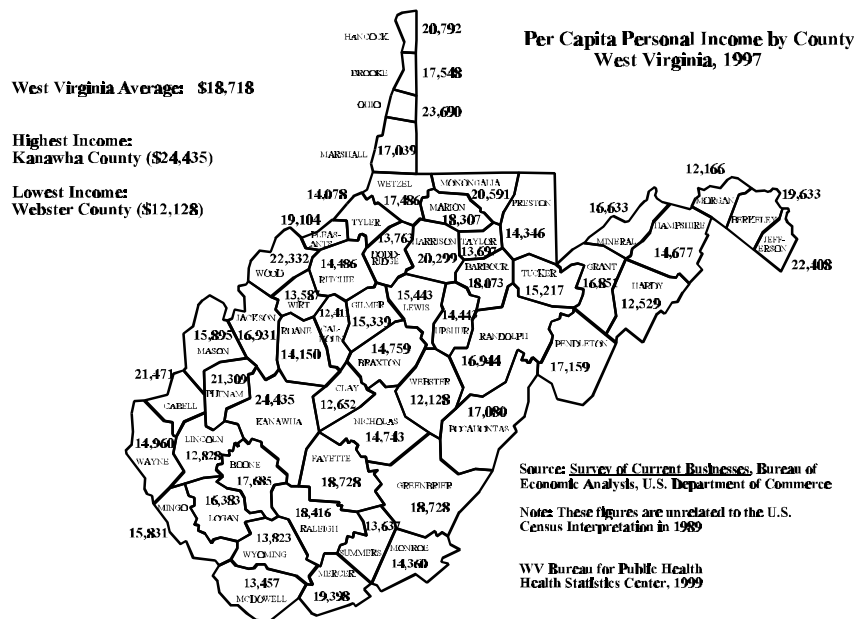
West Virginia's non-white population in 1998 was 69,700 persons, or 3.8 percent of total population, a slight increase from 67,954 or 3.7% in 1990. Eighty-three percent of the non-white population was Black, 13 percent was Asian or Pacific Islanders, and 4 percent was American Indian, Eskimo, or Aleutian. People of Hispanic origin (of any race) accounted for 10,296 persons, or 6% of the state's total population. The non-white population outgrew the white population between 1990 and 1998 (2.6% vs. 1.0%). Among minority groups, Asian and Pacific Islanders experienced by far the greatest population growth at 20.9% followed closely by Hispanics at 20.7%.

In 1990, almost 20 percent of all West Virginians 16 years and older and not living in institutions (273,451 people) were classified as being disabled, three percentage points higher than the US average of 17 percent. The highest concentrations of disabled adults are in the southern most counties of the state, followed by the central counties.

Income Characteristics: Personal income levels in West Virginia continue to lag behind the rest of the nation. The state's estimated 1996 median household income was \$25,822 or 73% of the US median of \$35,492, and ranked last among the 50 states. Likewise, West Virginia's 1997 per capita personal income was \$18,734, 74 percent of the national average of \$25,298 and 50th ranked among the states. The counties with the lowest per capita incomes are concentrated in the central interior and southwestern regions – these are rural areas with extraction-based economies.

Both the United States and West Virginia had an increase in the number of persons with incomes

below the poverty level between 1989 and 1996. The United States poverty rate increased from 13 percent of the population in 1989 to 13.5 percent in 1996. West Virginia's poverty rate increased from 17 percent in 1989 to 20 percent in 1996. The state ranks 50th in poverty. The areas with the highest poverty levels were the central interior region of the state and the southwestern coalfields.



Employment Characteristics: Total non-farm payroll employment in West Virginia increased by 88,400 between 1990 and 1998, a growth rate of 14 percent, compared to 15% nationally. Reflecting national growth patterns, West Virginia service jobs grew by more than 98,000 and wholesale and retail jobs grew by more than 18,000. However, these gains were offset in part by losses in the mining and manufacturing sectors, which decreased by 34 percent and 6 percent, respectively. Reflecting the latter trend, the highest percentages of job loss occurred in the northern panhandle and the southwestern regions.

Historically, there has been a large gap between the United States and West Virginia's labor force participation rates. In 1990, 66.4 percent of all American citizens above the age of 16 were participating in the workforce. In West Virginia, that number was more than 12 percentage points lower at 53.6%. That gap barely narrowed in 1998. At that time, West Virginia's population participating in the workforce was 54.8% (800,000 of 1,460,663 persons) while the national workforce participation rate was 67.1%.

One area that West Virginia fares better in mirroring the national trend is the rate of labor force participation by women. The 1997 national participation rate of women in the labor force was 48.3 percent. West Virginia's rate of women participating in the labor force had grown to 47 percent in 1997 from the 1990 count of 43.2 percent.

The counties with the highest labor force participation levels are in a corridor from Charleston to Parkersburg, some areas in the northern panhandle, the eastern panhandle and counties in the adjacent region. The lowest levels of labor force participation were in the central interior counties and southwest coalfields.

West Virginia's annual average unemployment rate from 1990 to 1998 remained significantly higher than the national average. While the state's rate averaged 8.8 percent during this time period, the national average was 5.4 percent, 3.4 percentage points lower. The unemployment rate in West Virginia continued to drop in 1998, falling three-tenths of a percentage point to 6.6 percent – the lowest annual rate since 1979. West Virginia's unemployment remained above the national average in 1998.

The counties with the lowest unemployment rates (3.1% to 6%) are located in the Kanawha Valley (Cabell, Putnam, and Kanawha), the Eastern Panhandle (Morgan, Berkeley, and Jefferson), and the Northern Panhandle (Hancock, Ohio, Marshall), along with Monongalia, Summers, Mercer, Pendleton, and Hardy Counties. Surprisingly, a number of west-central and interior counties, which typically lag behind the rest of the state in most types of growth, placed in the second best category of unemployment rates (6.1% to 9%). The reason for this can be found in two of the state's fastest-growing manufacturing industries, lumber/wood products and poultry processing coupled with the growing businesses of retail sales and tourism. The counties with the worst unemployment rates (greater than 9%) are concentrated in the southern coalfields and extreme central regions of the state, areas with extraction-based economies.

Health Care Delivery and Financing

Inventory of Health Care Facilities and Services

Adequate and accessible health care personnel, services, and facilities are essential in providing quality health care to all of West Virginia's residents. In 1998, 50 of the state's 55 counties were designated by the federal government as Medically Underserved Areas (MUAs).

Rural health care represents none of the most fragile aspects of the state's health care system. One way in which the state has addressed this problem is through the development of rural health alliances, or integrated health care delivery systems, referred to as rural health networks (RHNs). The formation of RHNs can improve the health of rural residents through the ability of the networks to link data systems, i.e., improve communication among segments of the health care industry, decrease duplication of services, recruit health personnel, address the needs of special populations, and improve access to care. Integration falls into three major categories: (1) physicians only, (2) physicians with provider organizations (hospitals, primary care centers, and ancillary sites), and (3) physicians, providers, and insurance entities. RHN development has

proceeded at different paces along the continuum of integration in different parts of the state; to date, however, the majority of work in RHN development in West Virginia has focused on the integration of providers to more cost effectively deliver health services. Networks hold the potential to improve the delivery and financing of rural health care by maintaining local access to care and supporting the implementation of managed care in rural areas.

Hospitals: As of 1998, 54 acute care hospitals in 41 counties were providing 10,239 beds for inpatient services. Residents in the state's remaining 14 counties access hospital-based services through facilities in neighboring counties. There are four Veterans Health Administration facilities located in Beckley, Clarksburg, Huntington, and Martinsburg that serve the state's estimated 1998 veteran population of 190,999.

Thirty-one (31) of the state's 54 acute care hospitals are designated as "small rural hospitals," i.e., acute care facilities with fewer than 100 beds, fewer than 5,000 admissions annually, and located in a rural community with a population of fewer than 10,000 persons. Of these, seven are designated as Critical Access Hospitals (CAHs), and others are considering such a conversion. Created under the Medicare Rural Hospital Flexibility Program (RHFP) and authorized by Congress in 1997, CAHs are acute care facilities that provide vital outpatient, emergency, and limited inpatient services. Small, rural hospitals are often the only providers of obstetric services, emergency care, primary care, and short-term inpatient care in the areas they serve. Increasingly, these hospitals are converting excess capacity to long-term care in response to a growing elderly population.

With the importance of rural hospital viability in mind, the West Virginia Legislature established the Rural Health Systems Program (RHSP) under WV Code 16-2D-5, to be jointly administered by the West Virginia Health Care Authority and the Office of Community and Rural Health Services (OCRHS) located within the Bureau for Public Health. The program was developed to assist financially vulnerable health care facilities located in underserved areas and to collaborate with other facilities to provide cost-effective services. To avoid potential crisis or collapse of essential rural health care services, the RHSP encourages the restructuring of the rural health care system through early intervention.

The principles of the RHSP are as follows: The program is to be driven by community-based decisions and is designed to reduce excess capacity and duplication of services. The intent is to assure that essential local health care services are provided. Linkages to secondary and tertiary services and facilities must be considered. Through technical assistance, grants, and loans, the program helps rural communities integrate and strengthen their health care delivery systems to assure access, and to prevent the loss of essential services in crisis situations. Since the inception of the RHSP, all certified CAHs in the state have received funds.

Hospital Utilization: According to a report by the RHFP, total inpatient utilization decreased by almost half during the 1980s from approximately 480,000 days in 1983 to 262,000 in 1988. Utilization increased again in the 1990s to an approximate 394,000 days in 1995. During that same period, the utilization of outpatient services increased 29% from 738,000 visits to more than 1,000,000 visits. In addition, long-term care admissions doubled between 1990 and 1995. The following table compares hospital admissions, inpatient days, and emergency room outpatient visits for West Virginia and the South Atlantic Region for the years 1992 through 1996. The table illustrates that the utilization of both inpatient and outpatient hospital services by West Virginians was consistently higher over the time period than that reported in the region as a whole. Studies by researchers at Dartmouth Medical College, in conjunction with the American Hospital Association (AHA), have indicated that the use of hospital services by a population is strongly affected by local practice patterns and the supply of resources, rather than the age and health of the

population.

Hospital Utilization Indicators, West Virginia and the South Atlantic Region (SAR)*, 1992-1996						
Year	Hospital Admissions per 1,000		Inpatient Days per 1,000		ER Outpatient Visits per 1,000	
	WV	SAR	WV	SAR	WV	SAR
1992	154.1	123.3	1064.6	864.0	559.5	376.1
1993	153.1	121.8	1035.4	833.4	568.2	386.5
1994	149.4	121.1	993.6	795.8	563.4	383.2
1995	148.2	121.5	974.5	763.9	569.5	379.9
1996	148.4	122.0	946.8	749.5	565.0	372.0
*Delaware, D.C., Florida, Georgia, Maryland, North Carolina, South Carolina, Virginia, West Virginia Source: AHA 1998 Hospital Statistics						

Intermediate and Skilled Nursing Facilities: Based on Office of Health Facility Licensure and Certification (OHFLAC) information, there were 106 freestanding licensed nursing homes in the state in 1999. These nursing homes have a total of 9,969 licensed beds. There are an additional 1,055 skilled nursing beds licensed among 34 hospitals. In addition, five state-owned long term care facilities have a total of 536 licensed beds. The total number of Medicaid-certified long-term care beds in West Virginia is 10,884.

Home Health Services: Home health services comprise an array of professional health and other related services to West Virginia individuals and families in their homes. These services include skilled nursing services and may include physical therapy, speech therapy, occupational therapy, nutritional services, homemaker and home health aide services, and/or other special medical services. In 1997, 103 West Virginia Certificate of Need-approved home health agencies provided care to 29,946 state residents. Gross patient revenue in that year totaled nearly \$173 million for 1,932,494 visits.

Personal Care/Residential Board and Care Facilities: Personal care homes provide alternative, community-based care for individuals who require limited and intermittent nursing care. Such care and treatment requires a living environment that approximates a normal home environment. Current regulations, as implemented by OHFLAC, stipulate that all health care facilities providing care to four to ten residents must be licensed by the West Virginia Bureau for Public Health.

According to OHFLAC, in 1999 there were 2,398 personal care beds in 58 open personal care homes in the state. Twenty-two (22) personal care homes (711 beds) are currently licensed by OHFLAC. These include personal care beds licensed and operated as a distinct unit by acute care hospitals. In addition, there are 842 (95 licensed) beds in 69 open residential board and care facilities, 12 of which were licensed in 1999.

Hospice Care: Hospice services provide in-home care to the terminally ill. Currently, there are 25 hospice agencies providing services in 53 of West Virginia's 55 counties. According to the Hospice 1997 Report of Facilities (provisional), there were 3,082 patients receiving hospice services in 1997. Moreover, 99 patients were served in nursing homes. Volunteers provided 45,648 hours of services to the hospice agencies.

Respite Care: Respite care provides temporary relief to a primary care giver usually responsible for the care of an impaired person needing constant care and supervision. Respite services are intended to prevent care giver exhaustion and to prevent nursing home or institutional placement. Respite care is provided by six hospitals, with 28 total respite beds licensed and staffed; 6,379 total respite inpatient days were reported for 1997.

Alternative Care Services: Communities have increased the availability of alternative care services, which can be offered in the outpatient setting for disabled individuals and the growing elderly population. The provision of such services can extend an individual's independence and postpone the need for long-term care.

Behavioral Health Facilities: Public and private behavioral health care facilities and programs in West Virginia provide a continuum of prevention, treatment, and rehabilitation services to individuals who have or are at risk of developing mental illness, developmental disabilities, or chemical dependency. The public behavioral health system includes 14 comprehensive behavioral health centers and two state-operated psychiatric hospitals (240 beds). The public behavioral health system currently serves about 65,000 individuals annually. In addition, there are two private freestanding psychiatric hospitals and 14 acute care hospitals with 561 beds.

The Office of Behavioral Health Services states that West Virginia has 84 intermediate care facilities with 1,339 beds for people with mental retardation. All 84 of these facilities are located in community settings. In April 1998, the Department of Health and Human Resources officially closed the Colin Anderson Center. **There are only five other states that have attained the goal of closing all institutions for persons who have developmental disabilities.**

Emergency Medical Services: The West Virginia Emergency Medical Services (EMS) System is patterned after the Federal Emergency Medical Services Systems Act of 1973, which provides guidelines and funding for development of regional EMS systems. The law established 15 components of the emergency medical services system. The state system is organized through the Office of Emergency Medical Services as the lead EMS agency within the Office of Community and Rural Health Services.

The RHFP reports that as of June 1997 there were 180 EMS agencies certified by the state EMS office, with 8,596 personnel certified as Emergency Medical Services Personnel to staff over 780 EMS vehicles and to provide out-of-hospital care. More than 82% of the EMS agencies were staffed by advanced

life support personnel, while the remaining agencies operate at the basic life support level. Often, basic life support squads are located in the more rural areas of the state, giving those residents more access to advanced life support services.

Local Health Departments: There are 54 local health departments in West Virginia (Wetzel and Tyler County health departments are combined), with 48 administrative centers. Each health department functions under the direction of a board of health, whose members are appointed by the county commissioner. The exceptions are those counties with combined boards of health whose members may be appointed by municipalities or several county commissioners.

There are approximately 655 full-time personnel employed by local health departments to provide public health services. Since local health departments receive only about 25% of their revenue from state and local governments, they provide some services for which they can generate fees.

Through the “Public Health Transitions Project,” a new program being implemented by the OCRHS, local health departments are networking more with other providers and re-evaluating their role and work force. The new program is an effort to improve public health functions by addressing public health from the perspective of the health care delivery system. An additional \$4.3 million was included in the state’s budget for this project.

Community Health Care

The overall health level of the population and the quality and accessibility of health care are important factors in the State’s quality of life and its attractiveness to new and expanding businesses. Four aspects of health care are particularly important: primary care, infant and maternal care, acute care, and long-term care. The status of each of these is discussed below.

The unequal distribution of professional health care manpower, particularly in rural areas, continues to be problematic for the state. As of September 1997, forty of West Virginia’s fifty-five counties (73 percent) were fully or partially designated by the federal government as Health Professional Shortage Areas. The designation means that the ratio of primary care physicians to the total population is less than 1:3500. The state has attempted to address this problem through several federal and state funded programs designed to place health professionals in communities with health manpower shortages and through use of tele-medicine technology to increase local physician access to information and specialist consultations.

There are 90 non-profit primary care centers located throughout West Virginia, with 42 of the state’s 55 counties receiving service. Current figures indicate that almost 1,000,000 patient encounters were projected by these primary care centers for 1991-1998. Eighty (80) primary care centers are located in the fifty (50) counties federally designated in whole or in part as Medically Underserved Areas (MUAs), thus making them eligible for federal assistance. These centers serve as the principal source of primary medical services in the rural Medically Underserved Areas of West Virginia, and they are often the only source of medical care

Health Professionals

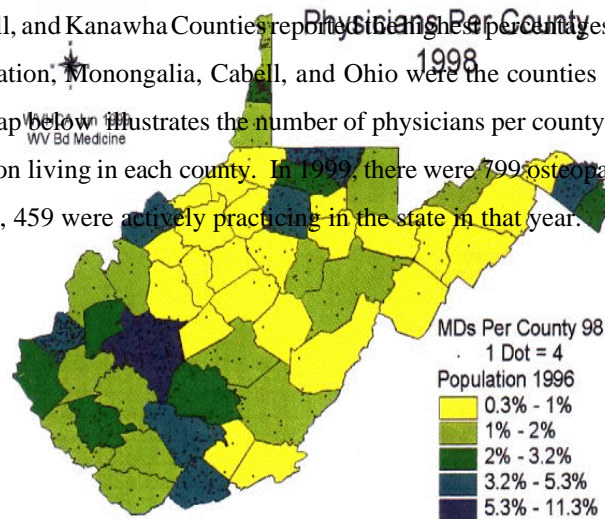
Physician shortages in rural areas have troubled West Virginia for years. The Division of Recruitment within OCRHS has worked with other state agencies and provider organizations to assist community efforts in alleviating health care provider shortages. The RHFP reports that at present there are requests for 136 primary care physicians for rural underserved areas of the state; 61 family practitioners, 30 internists, 22 pediatricians, and 21 obstetricians/gynecologists. In addition there are requests for non-physician providers, i.e., nurse practitioners, physician assistants, and certified nurse midwives.

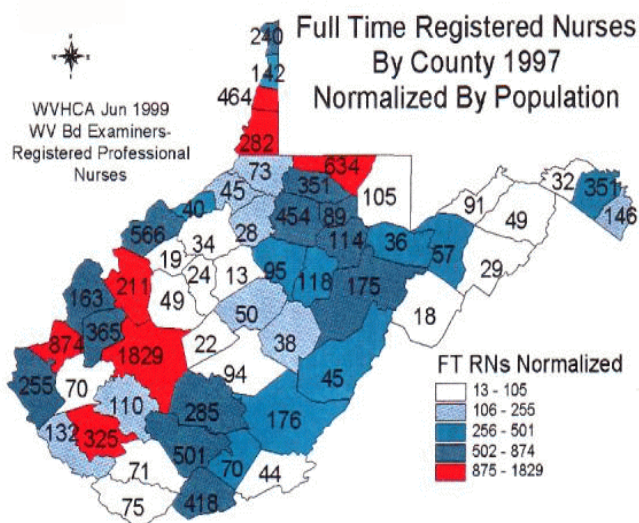


Other Health Professions. In addition to physicians, the following counts were obtained for other health professions practicing in the state. In all cases, the numbers represent the most recent year of collection by the respective licensing boards.

Dentists	811	Basic EMT Staff	4,657
Dental Hygienists	597	Ambulance EMTs	825
Pharmacists	1,672	Nonaffiliated EMTs	418
Chiropractors	199	Mining EMTs	2,338
Psychologists	583	Paramedic EMTs	1,300
Registered Nurses	15,000	Registered CNAs	15,589
LPNs	5,696	Physician Assistants	321
		Radiologic Technicians	2,500

Physicians: In 1998, the latest year for which data are available from the West Virginia Bureau for Public Health (WVBPH), there were 5,076 M.D.s with active licenses, 3,395 of whom were actively practicing in West Virginia. The specialties most frequently listed by M.D.s were internal medicine and family practice. Monongalia, Cabell, and Kanawha Counties reported the highest percentages of a specialists. However, when adjusted for population, Monongalia, Cabell, and Ohio were the counties with the highest percentages of specialists. The map below illustrates the number of physicians per county, in addition to the percentage of total state population living in each county. In 1999, there were 799 osteopathic physicians licensed in West Virginia. Of these, 459 were actively practicing in the state in that year.





Measuring Medical Provider Participation (Access)

Ensuring adequate provider participation in public programs for low-income populations has been an on-going concern for state and federal officials. As Medicaid has expanded to cover more pregnant women and more children, West Virginia has used a variety of approaches to recruit and retain providers willing to serve the growing number of recipients.

MCH has monitored provider participation in an effort to identify gaps in service availability and/or insufficient access to care. Measurement of participation is not the provider's receipt of a Medicaid provider number but rather active service utilization.

Environment: Child Health

The 1990 census reports that of the 688,557 occupied dwelling units in the state, 465,167 (66.2 percent) were built prior to 1960. The state estimates that of the 465,167 units built prior to 1960, 72,987 are in some disrepair and may have old cracking and/or peeling paint contributing to a lead poisoning hazard. Poverty level families and dependent children are more likely to reside in these structures. A study conducted by the Bureau for Public Health, Office of Maternal and Child Health (OMCH), found that of the estimated 128,000 children living in poverty in 1995, 21,512 children under six years of age had an elevated lead blood

level. The State of West Virginia began actively pursuing lead poison testing in early 1992, but subsequent lack of sufficient legislative appropriations and field equipment has restrained the program.

Passage of the West Virginia Lead Abatement Law, Chapter 16-35, in 1998 strengthens training and oversight of lead abatement providers and projects. Portions of HUD's new lead-based paint regulation took effect November 15, 1999, while most of the regulation will take effect September 15, 2000. The state currently has 42 contractors and other professionals qualified to perform lead evaluation services pursuant to the new HUD regulations. Twenty-six companies are qualified to perform lead hazard control services in the state. Since implementation, the state's HOME Program has followed and will continue to follow the policy of abating lead-based paint during rehabilitation or reconstruction of homes identified as having a lead-based paint problem as efficiently as possible under the Federal regulations of the HOME Program.

County Composite Index of High Risk for Childhood Lead Poisoning Z-Score and Frequency of Confirmed Elevated Blood Lead by Level and County of Residence West Virginia Childhood Lead Poisoning Prevention Project: July 1, 1995 - March 1, 1999 Data						
County	Composite or Index Z-Score	Ranking of Need*	Confirmed Elevated Blood Lead Cases ≥10 - 14.9	Confirmed Elevated Blood Lead Cases ≥15 - 19.9	Confirmed Elevated Blood Lead Cases ≥20	Total Confirmed Elevated Blood Lead Cases ≥10 - ≥ 20
Barbour	.544	18	0	1	0	1
Berkeley	-1.918	50	3	5	3	11
Boone	.198	25	3	0	1	4
Braxton	1.559	7	3	0	0	3
Brooke	-1.432	49	0	1	1	2
Cabell	.713	14	12	3	9	24
Calhoun	2.698	4	0	0	0	0
Clay	2.721	3	10	1	0	11
Doddridge	.867	12	10	4	3	17
Fayette	1.344	9	10	4	1	15
Gilmer	.229	23	2	3	0	5
Grant	-2.554	53	4	0	0	4
Greenbrier	-.576	40	3	0	0	3
Hampshire	-.427	36	3	0	0	3
Hancock	-1.380	48	3	3	3	9

County Composite Index of High Risk for Childhood Lead Poisoning Z-Score and Frequency of Confirmed Elevated Blood Lead by Level and County of Residence West Virginia Childhood Lead Poisoning Prevention Project: July 1, 1995 - March 1, 1999 Data						
County	Composite or Index Z-Score	Ranking of Need*	Confirmed Elevated Blood Lead Cases ≥10 - 14.9	Confirmed Elevated Blood Lead Cases ≥15 - 19.9	Confirmed Elevated Blood Lead Cases ≥20	Total Confirmed Elevated Blood Lead Cases ≥10 - ≥ 20
Hardy	-.909	45	1	1	0	2
Harrison	.938	11	7	4	2	13
Jackson	-.573	39	8	1	1	10
Jefferson	-2.054	52	1	1	0	2
Kanawha	-.078	30	18	10	4	32
Lewis	.597	17	10	5	4	19
Lincoln	.643	16	6	2	1	9
Logan	-.47	37	4	1	0	5
Marion	-.064	29	16	10	9	35
Marshall	.371	21	5	2	1	8
Mason	-.117	31	1	0	2	3
McDowell	5.272	1	5	4	3	12
Mercer	.049	28	29	15	6	50
Mineral	-.302	35	4	2	0	6
Mingo	1.674	6	3	1	3	7
Monongalia	-1.99	51	4	2	8	14
Monroe	-.795	44	2	1	0	3
Morgan	-4.155	55	0	0	0	0
Nicholas	.483	19	18	10	0	28
Ohio	1.476	8	4	4	1	9
Pendleton	-.12	32	0	0	0	0
Pleasants	-.622	41	3	4	1	8
Pocahontas	-.963	46	0	1	0	1

County Composite Index of High Risk for Childhood Lead Poisoning Z-Score and Frequency of Confirmed Elevated Blood Lead by Level and County of Residence West Virginia Childhood Lead Poisoning Prevention Project: July 1, 1995 - March 1, 1999 Data						
County	Composite or Index Z-Score	Ranking of Need*	Confirmed Elevated Blood Lead Cases ≥10 - 14.9	Confirmed Elevated Blood Lead Cases ≥15 - 19.9	Confirmed Elevated Blood Lead Cases ≥20	Total Confirmed Elevated Blood Lead Cases ≥10 - ≥ 20
Preston	.25	22	6	3	3	12
Putnam	-.501	38	3	0	0	3
Raleigh	-.136	33	20	5	3	28
Randolph	.072	26	1	0	1	2
Ritchie	.833	13	13	1	3	17
Roane	.149	25	1	0	0	1
Summers	-.647	42	1	1	1	3
Taylor	1.971	5	7	1	1	9
Tucker	-1.21	47	0	0	0	0
Tyler	.222	24	4	1	2	7
Upshur	-.748	43	11	3	1	15
Wayne	-3.285	54	0	0	3	3
Webster	3.087	2	9	2	0	11
Wetzel	1.286	10	13	1	1	15
Wirt	-.176	34	1	0	0	1
Wood	.439	20	12	6	4	22
Wyoming	.675	15	7	0	0	7
Unknown	NA	NA	222	29	20	271
TOTAL	NA	NA	546	159	110	815

The majority of overall renter demand derives from lower income household (under \$26,000). However, the National Low-Income Housing Coalition (NLHC) report, *Out of Reach*, estimates that 45% of West Virginia renters are unable to afford Fair Market Rent for a two-bedroom unit, and 38% are unable to afford Fair Market Rent for a one-bedroom unit. In fact, the state ranked among the least affordable states

in terms of percent of combined non-metro area renters unable to afford a two-bedroom unit at FMR. In addition, the 1994 data tables indicate that among extremely low-income renter households (those with incomes less than 30% of median), 10,371 spend between 30% and 50% of income for housing costs, while 17,419 spend over 50% of income. Another 15,615 renter household with incomes between 31% and 50% of median spend more than 30% of their income on housing costs. The unaffordability of Fair Market Rents for many of the state's renter households indicates that the problem of high renter cost burden may not be solved without deep rent subsidies and/or higher incomes.

C A similar pattern is observed among low-income owner households; the highest incidence of housing problems occurs in larger related households (56%), followed by small related households (41%) and elderly households (26%). However, small related households again have the highest numbers of housing problems (26,965 households), followed closely by elderly households (23,539), and large related households (8,067).

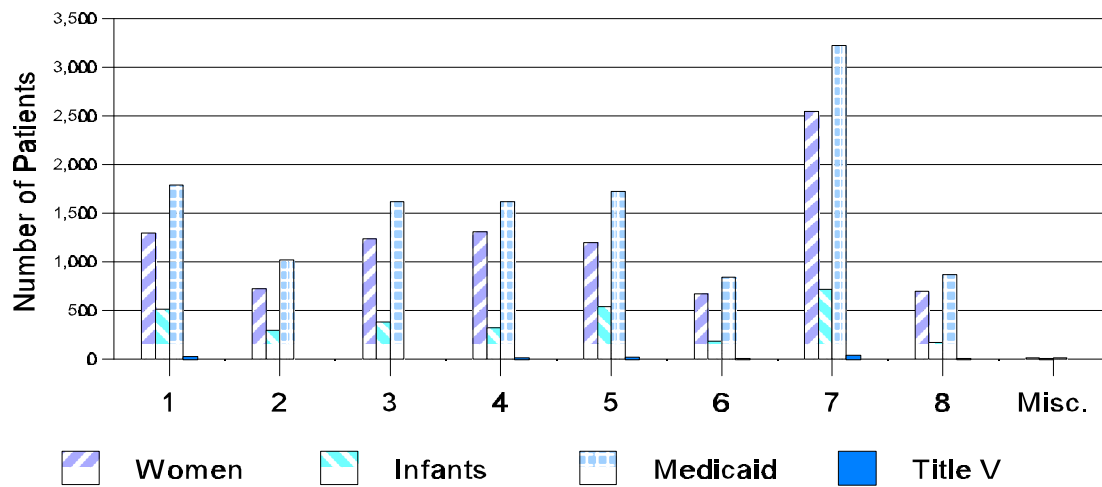
C In 1998, very low-income households (below \$13,000 annual income) accounted for 50,250 potential home buyers, or 45% of ownership demand for that year. Low-income households (between \$13,000 and \$26,000 annual income) accounted for 26,850 potential home buyer households (24% of demand). Although lower income households comprise the majority of ownership demand, these households are the least able to purchase a home. Based on 1997 home sale price data, only 4.2% of very low-income and 11.8% of low-income households would succeed in purchasing a home.

Services and Service Linkages in West Virginia

Public Transit: West Virginia's low population density and mountainous rural terrain make public transportation an expensive commodity. Many areas lack the necessary local matching money needed to draw down federal grants. Additionally, federal funds do not provide sufficient resources to meet the public transit needs of the state. Welfare reform efforts have also identified the lack of transportation as a barrier to acquiring and maintaining employment. The expansion of transportation services continues to be a high priority for West Virginia's economic development, in addition to improved health care access. PRAMS survey reporting consistently cites transportation as a barrier to health care access.

In response to this concern, the OMCH initiated a project in 1992, Access to Rural Transportation (ART) to improve health care utilization for vulnerable perinatal populations statewide. This project is locally administered and provides funds to defray transportation cost when seeking non-emergency medical care. The Project is unique in that the monies for gasoline or to pay a neighbor to transport, etc. are paid in advance.

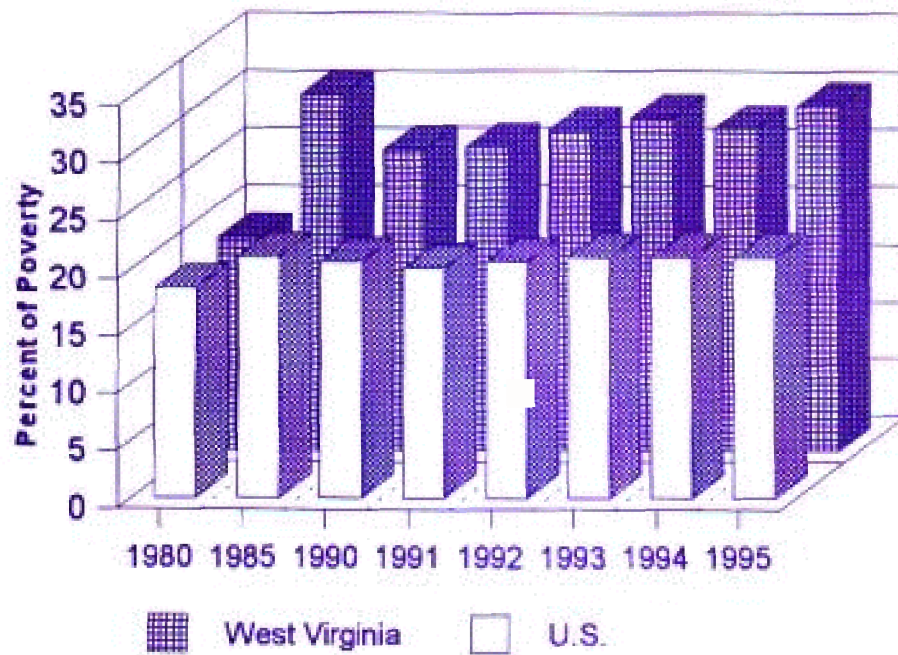
ART Utilization - 1999

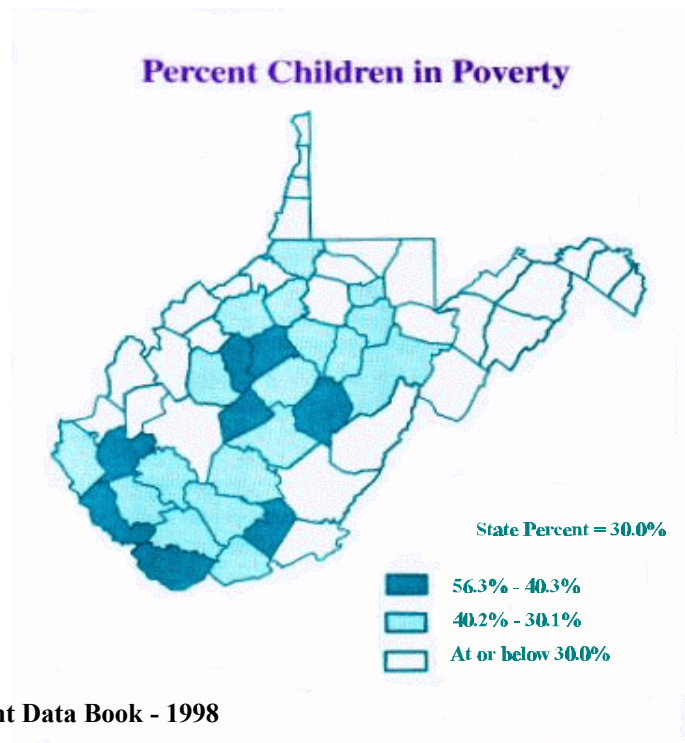


Services to Low Income Persons

Poverty continues to be a major problem in West Virginia. According to the US Census Bureau's Poverty Model/Estimates for 1996, 20% of West Virginia's total population - 362,984 persons - live in poverty, compared to 13.7% for the nation as a whole. The same report indicates that more than 126,000 or 29.9% of all children, persons under age 18, live in poverty in West Virginia. Nationally, that average is 20.5%. The 1999 Kids Count Report states that 32% of West Virginia's children rely on Medicaid or other public-sector health insurance while the national average is 25%. Additionally, 12% of all West Virginia children are without health insurance.

**Trends in the Percent of Children in Poverty in WV
1980-1995**

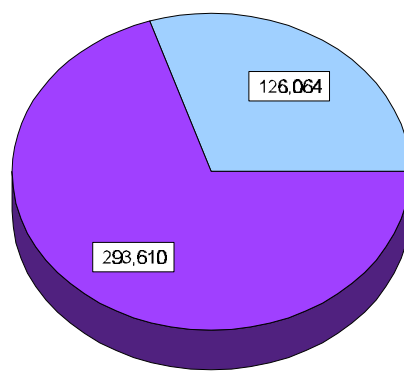




Source: WV Kids Count Data Book - 1998

WV Children Living in Poverty

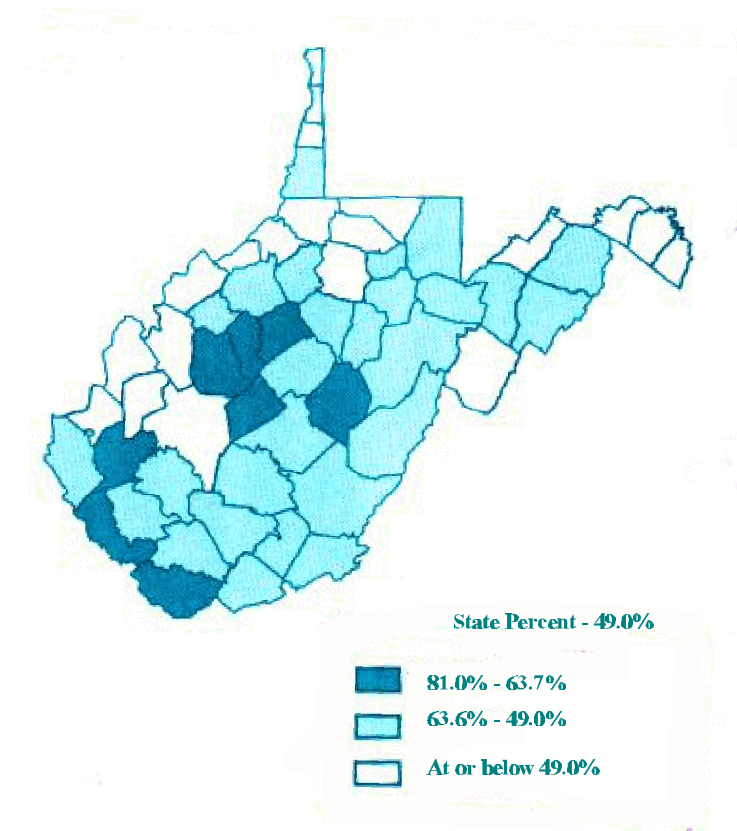
(Under Age 18)



Children Living in Poverty

Total Child Population, Under 18 Years:	419,674 (estimated)
# Children, Under Age 18, Living in Poverty:	126,064
Data Source:	U.S. Census Bureau Estimates

**Percent of Children Approved for Free and Reduced Priced School Meals
(Grades K-12)**



Children are eligible to receive free meals if their family income is below 130 percent of poverty. Reduced-priced meals are provided to children with a family income between 130 and 185 percent of poverty. Like the child poverty rate, the school meal rate continues to climb. In 1998, 49 percent of our school children K-12 received free or reduced-priced school meals. In 1998, one out of 2 children received free and reduced price school meals. The county serving the highest number of children is McDowell, where 82.4 percent of the school children participate in the program.

WEST VIRGINIA - HEALTH STATUS OVERVIEW

In comparison to the U.S., West Virginia is

<p>Better*</p> <p>Breast Cancer Teen Fertility Rate Births to Unwed Mothers Late (3rd Tri)/No Prenatal Care Fetal Deaths Binge Drinking Homicide</p>
<p>Similar</p> <p>Colon Cancer Pneumonia and Influenza Low-Birthweight Births Infant Deaths</p>
<p>Worse*</p> <p>Diseases of the Heart Cancer - All Causes Lung Cancer Cancer - All Other Causes Cerebrovascular Disease Chronic Obstructive Pulmonary Disease Unintentional Injuries Motor Vehicle Accidents Non-Motor Vehicle Accidents All Other Causes YPLL - All Causes Sedentary Lifestyle Obesity Hypertension Seatbelt Nonuse Cigarette Smoking Smokeless Tobacco Use No Health Insurance, Ages 18-64 Difficulty Seeing Doctor Because of Cost Suicide</p>

*A statistically significant difference from the U.S.

Information is available on a county-specific basis using the same health indicators.

Source: WV Statistics Center

WEST VIRGINIA VITAL STATISTICS SUMMARY 1998

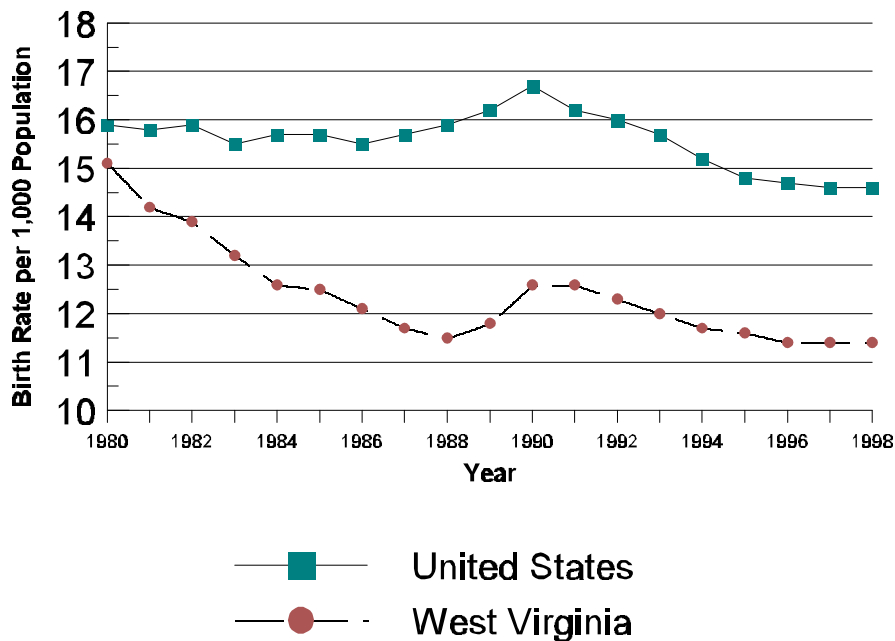
Population

For the second year in a row, more state residents died than were born. Thirty-five (35) West Virginians were lost to the total population in 1998 as a result of natural decrease, the excess of deaths over births. The rate of natural decrease was 0.02 persons per 1,000 population. Population estimates for 1998 show a total decrease in the state's population (approximately 0.3%) since 1997, from 1,816,000 to 1,811,000. This decrease is the result of the natural decrease and an excess of out migration over immigration.

Live Births

West Virginia resident live births decreased by six, from 20,735 in 1997 to 20,729 in 1998. The 1998 birth rate of 11.4 per 1,000 population was the same as the 1997 rate. The U.S. 1998 provisional birth rate was 14.6 live births per 1,000 population, unchanged from 1997. As the graph below shows, West Virginia's birth rate first fell below the national rate in 1980. It has continued its overall decline, interrupted by slight upturns between 1989 and 1991.

**West Virginia and United States Birth Rates
1980-1998**



The 1998 U.S. fertility rate of 65.6 live births per 1,000 women aged 15-44 was 0.5% higher than the 1997 rate (65.3). West Virginia's fertility rate increased from 51.8 in 1997 to 53.7 in 1998. A comparison of West Virginia and United States age-specific fertility rates is displayed in the table below.

Fertility Rates* by Age Group West Virginia and United States, 1998					
15-19		20-44		Total (15-44)	
WV	U.S.**	WV	U.S.**	WV	U.S.**
48.6	51.1	54.2	68.1	53.7	65.6

*All fertility rates were calculated using 1998 estimates, U.S. Department of Commerce, Bureau of the Census.

**National Center for Health Statistics, *Monthly Vital Statistics Report*, Vol. 47, No. 25, October 5, 1999

The fertility rate among women aged 15-19 in West Virginia was 4.9% lower than that among young women in the U.S. (48.6 vs. 51.1). The fertility rate among women aged 20-44, however, was 20.4% lower in the state than in the nation (54.2 vs. 68.1)

The number of births to teenage mothers decreased by 68 (2.1%), from 3,288 in 1997 to 3,220 in 1998. The percentage of total births decreased from 15.9% in 1997 to 15.5% in 1998. The significantly lower fertility rate among older women, however, resulted in teenage births continuing to constitute a higher proportion of total births than is found nationally (12.3% in 1998).

The percentage of births occurring out of wedlock has continued to rise steadily over the past decade, except between 1996 and 1997. In 1998 nearly one out of every three (32.3%) West Virginia resident births was to an unwed mother. The percentages of white and black births that occurred out of wedlock in West Virginia in 1998 were 30.8% and 76.6%, respectively, compared to 29.7% and 75.9% in 1997. In the United States in 1998, 26.3% of white births and 69.0% of births to black mothers occurred out of wedlock. The percentage of teenage births to unmarried mothers in the state increased from 69.7% to 71.0% in 1998.

There were a total of 1,675 low birthweight babies (those weighing less than 2,500 grams or 5-1/2 pounds) born to West Virginia residents in 1998, 8.1% of all births. Of the 1,559 low birthweight infants with known gestational age, 1,011 or 64.8% were preterm babies born before 37 weeks of gestation. (Of all 1998 resident births with a known gestational age, 13.0% were preterm babies.) Of the births with known birthweight, 13.1% of black babies and 7.9% of the white babies were low birthweight. Nationally, 7.6% of all infants weighed less than 2,500 grams at birth in 1998; 6.6% of white infants and 13.0% of black infants were of low birthweight.

Over eighty percent (83.7%) of West Virginia mothers who received known prenatal care began their care during the first trimester of pregnancy compared to 82.8% of mothers nationwide in 1998. Among those with known prenatal care, 84.2% of the white mothers began care during the first trimester; 70.5% of black mothers did so. No prenatal care was received by 0.5% of white mothers and by 1.7% of black mothers.

Over one-fourth (25.4%) of the 20,729 births in 1998 were to mothers who smoked during their pregnancies, while 1.0% of births were to women who used alcohol. The most recent national figures show that 13.6% of women giving birth reported smoking during pregnancy (1996) and 1.5% used alcohol (1995). Twenty-four percent (24.1%) of 1998 state births were delivered by Cesarean section, compared to a national rate of 21.2%. One or more complications of labor and/or delivery were reported for 33.4% of deliveries in the state in 1998.

Deaths

The number of West Virginia resident deaths decreased from 20,872 in 1997 to 20,764 in 1998. The state's crude death rate stayed at 11.5 per 1,000 population. The nation's 1998 provisional death rate also remained unchanged in 1998 at 8.6 per 1,000. The average age at death for West Virginians was 72.7 (69.4 for men and 75.9 for women). One hundred and forty-six West Virginia residents who died in 1998 were age 100 or older. The oldest man was 104 years old at the time of death, while the oldest woman was 112 years old.

Heart disease, cancer, and stroke, the three leading causes of death, accounted for 61.7% of West Virginia resident deaths and 60.8% of the United States deaths in 1998. Compared to 1997, the number of state deaths due to heart disease decreased 0.6% while cancer deaths decreased 0.7%. Deaths due to stroke decreased (2.6%), while chronic obstructive pulmonary disease mortality increased (0.5%). Diabetes mellitus deaths increased 4.7%, while the number of reported deaths due to pneumonia and influenza was exactly the same (712 in both 1997 and 1998). Mortality resulting from unintentional injuries increased 3.3% from 788 in 1997 to 814 in 1998. Motor vehicle traffic accidents continued to be below the 424 deaths in 1993, the year the West Virginia seatbelt law took effect, decreasing by 3 (0.8%) from 389 in 1997 to 386 in 1998.

Unintentional injuries remained the leading cause of death for ages 1 through 34 years. Even with the precipitous drop in motor vehicle accident deaths between 1993 and 1994, such fatalities remained the single leading cause of death for young adults aged 15 through 34, accounting for 30.2% of all deaths for this age group in 1998, compared with 30.8% in 1997. West Virginia's 1998 motor vehicle fatalities included three children under five years of age, the same as in 1997.

Suicides decreased 37 (261 to 224 or 14.2%) between 1997 and 1998. Male suicides decreased 13.7% from 219 in 1997 to 189 in 1998; the number of female suicides (35) decreased by seven or 16.7% from 1997. Over seventy percent (71.9%) of all suicide deaths were firearm related — 75.1% of male suicides and

54.3% of female suicides. The average age of death for a suicide victim in 1998 was 45.4 years. While suicide was the ninth leading cause of death overall, it was still the second leading cause of death for ages 15-34. The number of suicides among persons aged 19 and under rose by one, from 16 in 1997 to 17 in 1998.

Homicides in West Virginia increased by one, from 94 in 1997 to 95 in 1998. Sixty-four of the homicide victims were male, 31 were female. The average age at death for a homicide victim in 1998 was 37.6 years. There were three homicide victims under the age of five in 1998, compared to six in 1997. Over sixty percent (63.2%) of 1998 homicide deaths were due to firearms.

Years of Potential Life Lost (YPLL)

Years of Potential Life Lost is a measure of premature or preventable mortality occurring before the age of 65, calculated as the difference between age 65 and the age at death. The sum of YPLL over all causes is the total YPLL from all persons dying before the age of 65. For example, a person dying at the age of 45 contributes 20 years total to the total YPLL (65-45 = 20 YPLL). YPLL is an important tool for emphasizing and evaluating causes of death among persons less than 65 years of age.

The YPLL from all causes decreased marginally, from 81,248 YPLL in 1997 to 81,212 in 1998. The three leading causes of YPLL in 1998 were malignant neoplasms (15,410 YPLL), diseases of the heart (14,038 YPLL), and motor vehicle accidents (10,313 YPLL). Combined, these three causes accounted for almost half (49.0%) of all years of potential life lost in 1998. In comparison to 1997, YPLL attributable to malignant neoplasms increased from 18.6% of the total to 19.0%. YPLL due to diseases of the heart also increased from 15.3% to 17.3% while the percentage of total YPLL due to motor vehicle crashes increased from 12.6% to 12.7%.

Infant Deaths

Deaths of infants under one year of age decreased from 197 in 1997 to 167 in 1998. West Virginia's infant mortality rate decreased noticeable (14.7%), from 9.5 per 1,000 live births in 1997 to 8.1 in 1998. The U.S. provisional 1998 infant mortality rate was 7.2, unchanged from 1997.

1998 West Virginia and United States Infant Mortality by Race (Number and Rate per 1,000 Live Births)				
Race of Infant	West Virginia		United States	
	Number	Rate	Number	Rate
All Races	167	8.1	28,486	7.2
White	159	8.0	18,795	6.0
Black	8	10.6	8,579	14.1
Other	0	0.0	1,112	5.3

Approximately one in five (21.0%) infant deaths in 1998 was due to SIDS (sudden infant death syndrome). Twenty-five percent (24.6%) were the result of congenital anomalies, while 40.7% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birthweight (8.4%).

The table below shows the decline in the national and state infant mortality rates from 1950 through 1998.

1950 - 1998 Infant Mortality West Virginia and United States (Number and Rate per 1,000 Live Births)		
Year	West Virginia	United States
1950	31.4	29.2
1955	27.1	26.4
1960	25.3	26.0
1965	27.1	24.5
1970	23.3	20.2
1975	18.3	16.1
1980	11.8	12.6
1985	10.7	10.6
1990	9.8	9.1
1991	8.1	8.9
1992	9.1	8.5
1993	8.6	8.3
1994	6.1	8.0
1995	7.6	7.5
1996	7.2	7.2
1997	9.5	7.2
1998	8.1	7.2

The ten (10) leading causes of infant deaths have not changed significantly over the past several years. We do attribute past decreases in SIDS deaths and respiratory distress syndrome with improvements in the infant mortality rate.

Causes of infant death for WV residents, 1994-1998 are portrayed below.

**Causes of Infant Deaths
West Virginia Residents, 1994-1998**

Cause of Death		1994	1995	1996	1997	1998	Total
001-999	Total Deaths, All Causes	131	160	150	197	167	805
036	Meningococcal Infection	1	0	0	0	0	1
038	Septicemia	0	2	0	1	2	5
045-079	Viral Diseases	0	0	1	0	0	1
140-208	Malignant Neoplasms	0	1	0	0	1	2
210-239	Benign Neoplasms, Carcinoma in Situ, and Neoplasms of Unspecified Nature	1	0	0	0	0	1

Cause of Death		1994	1995	1996	1997	1998	Total
320-322	Meningitis	0	1	1	1	0	3
323-389	Other Diseases of Nervous System and Sense Organs	1	1	2	1	2	7
390-398, 402, 404- 429	Diseases of the Heart	1	2	1	4	3	11
466, 490- 491	Bronchitis and Bronchiolitis	0	0	0	1	0	1
480-487	Pneumonia and Influenza	3	1	1	0	3	8
480-486	Pneumonia	3	1	1	0	3	8
550-552, 560	Hernia of Abdominal Cavity and Intestinal Obstruction	1	0	0	0	0	1
553, 555- 558	Gastritis, Duodenitis, and Noninfective Enteritis Colitis	0	0	1	1	1	3
740-759	Congenital Anomalies	38	39	42	55	41	215
740	Anencephalus and Similar Anomalies	2	5	2	3	0	12
741	Spina Bifida	0	0	0	1	0	1
742	Other Congenital Anomalies of Nervous System	3	4	3	1	6	17
742.3	Congenital Hydrocephalus	1	2	0	1	2	6
745-746	Congenital Anomalies of Heart	9	17	11	21	13	71
747	Other Congenital Anomalies of Circulatory System	0	1	2	1	4	8
748	Congenital Anomalies of Respiratory System	10	4	7	4	7	32
749-751	Congenital Anomalies of Digestive System	0	0	0	2	0	2
752-753	Congenital Anomalies of Genitourinary System	1	0	7	2	3	13
754-756	Congenital Anomalies of Musculoskeletal System	4	2	2	5	3	16
758	Chromosomal Anomalies	4	1	6	7	1	19
758.0	Down's Syndrome	0	0	1	1	0	2
744,757, 759	Other and Unspecified Congenital Anomalies	5	5	2	8	4	24
760-779	Certain Conditions Originating in the Perinatal Period	48	74	65	85	68	340
760	Newborn Affected by Maternal Conditions Which May be Unrelated to Present Pregnancy	0	1	3	5	2	11
761	Newborn Affected by Maternal Complications of Pregnancy	3	2	3	6	7	21
762	Newborn Affected by Complications of Placenta, Cord and Membranes	3	7	3	10	7	30
763	Newborn Affected by Other Complications of Labor and Delivery	0	0	0	0	1	1
764	Slow Fetal Growth and Fetal Malnutrition	0	0	0	1	0	1
765	Disorders Relating to Short Gestation and Unspecified Lowbirth Weight	17	24	20	18	14	93
767	Birth Trauma	1	1	1	2	1	6
768	Intrauterine Hypoxia and Birth Asphyxia	0	1	2	3	1	7
768.2-768.4	Fetal Distress in Liveborn Infant	0	0	1	0	0	1
768.5-768.9	Birth Asphyxia	0	1	1	3	1	6
769	Respiratory Distress Syndrome	9	10	11	12	3	45
770	Other Respiratory Conditions of Newborn	5	11	12	13	20	61
771	infections Specific to the Perinatal Period	1	5	6	5	6	23

Cause of Death		1994	1995	1996	1997	1998	Total
772	Neonatal Hemorrhage	2	1	1	1	2	7
775	Endocrine and Metabolic Disturbances Specific to Newborn	0	0	0	1	0	1
776.1-779	All Other and Ill-Defined Conditions Originating in Perinatal Period	7	11	3	8	4	33
780-799	Symptoms, Signs, and Ill-Defined Conditions	30	30	27	37	38	162
798.0	Sudden Infant Death Syndrome	27	21	23	35	35	141
E800-999	External Causes of Injury and Poisoning	2	4	7	6	7	26
E800-949	Unintentional Injuries, All Forms	1	2	3	3	2	11
E810-825	Motor Vehicle Crashes	0	1	1	1	0	3
E910-915	Unintentional Injuries Caused by Submersion, Suffocation and Foreign Bodies	1	1	1	2	1	6
E911	Inhalation and Ingestion of Food Causing Obstruction of Respiratory Tract or Suffocation	1	1	0	0	0	2
E913	Unintentional Mechanical Suffocation	0	0	1	0	1	2
E960-969	Homicide	0	2	2	3	2	9
E967	Child Battering and Other Maltreatment	0	1	0	2	0	3
Residual	All Other Causes (Residual)	5	5	2	5	1	18

Source: WVDHHR/BPH/OEHP/Health Statistics/02-00

Neonatal/Postneonatal Deaths

The number of neonatal deaths decreased by 38, from 133 in 1997 to 95 in 1998; the neonatal death rate decreased from 6.4 deaths among infants under 28 days per 1,000 live births in 1997 to 4.6 in 1998. The United States provisional 1998 rate was 4.8. Neonatal deaths comprised over half (56.9%) of all West Virginia resident infant deaths in 1998, compared to 67.5% in 1997. The rate of postneonatal deaths increased from 3.1 deaths per 1,000 neonatal survivors in 1997 to 3.5 in 1998.

Fetal Deaths

The 125 resident fetal deaths occurring after 20 or more weeks of gestation reported in 1998 were 13 fewer than the 138 fetal deaths in 1997. The fetal death ratio decreased from 6.5 deaths per 1,000 live births in 1997 to 6.0 in 1998. The majority (91.2%) of fetal deaths were due to conditions originating in the perinatal period, including complications of placenta, cord, and membrane (30.4%), maternal conditions (7.2%), maternal complications (9.6%), short gestation and low birthweight (6.4%), and other ill-defined perinatal conditions (28.8%). Congenital anomalies accounted for 8.0% of all fetal deaths.

Marriages

Marriages increased from 10,530 in 1997 to 10,839 in 1998. The marriage rate in 1998 was 6.0 per 1,000 population, compared to 5.8 in 1997. The state's 1998 marriage rate was 27.7% lower than the provisional U.S. rate of 8.3, down from 8.9 in 1997.

The median age for all marriages in 1998 was 25 for brides and 27 for grooms. For first marriages, the median age was 22 for brides and 24 for grooms. The mode (most frequently reported age) for all marriages, and for first marriages, was 22 for brides and 23 for grooms.

Divorces and Annulments

The number of divorces rose from 8,998 in 1997 to 9,309 in 1998. The 1998 rate of 5.1 per 1,000 population also increased from 5.0 in 1997. The 1998 U.S. provisional rate was 4.2 per 1,000 population, down from 4.3 in 1997.

Of the 9,309 divorces in West Virginia in 1998, the median duration of marriage was seven years. Over half (50.7%) of the divorces involved no children under 18 years of age in the family, while one child was involved in 25.6% of all divorces and two children were involved in 17.6%. Fourteen divorces involved six or more children.

Summary

The number of West Virginia resident births decreased only six from 20,735 in 1997 to 20,729 in 1998. West Virginia resident deaths also decreased from 20,872 in 1997 to 20,764 in 1998. The number of infant deaths decreased from 197 in 1997 to 167 in 1998. Fetal deaths of 20 or more weeks gestation decreased by 13, from 138 in 1997 to 125 in 1998. Marriages increased for the first time since 1994, from 10,530 in 1997 to 10,839 in 1998, while divorces also increased from 8,998 in 1997 to 9,309 in 1998.

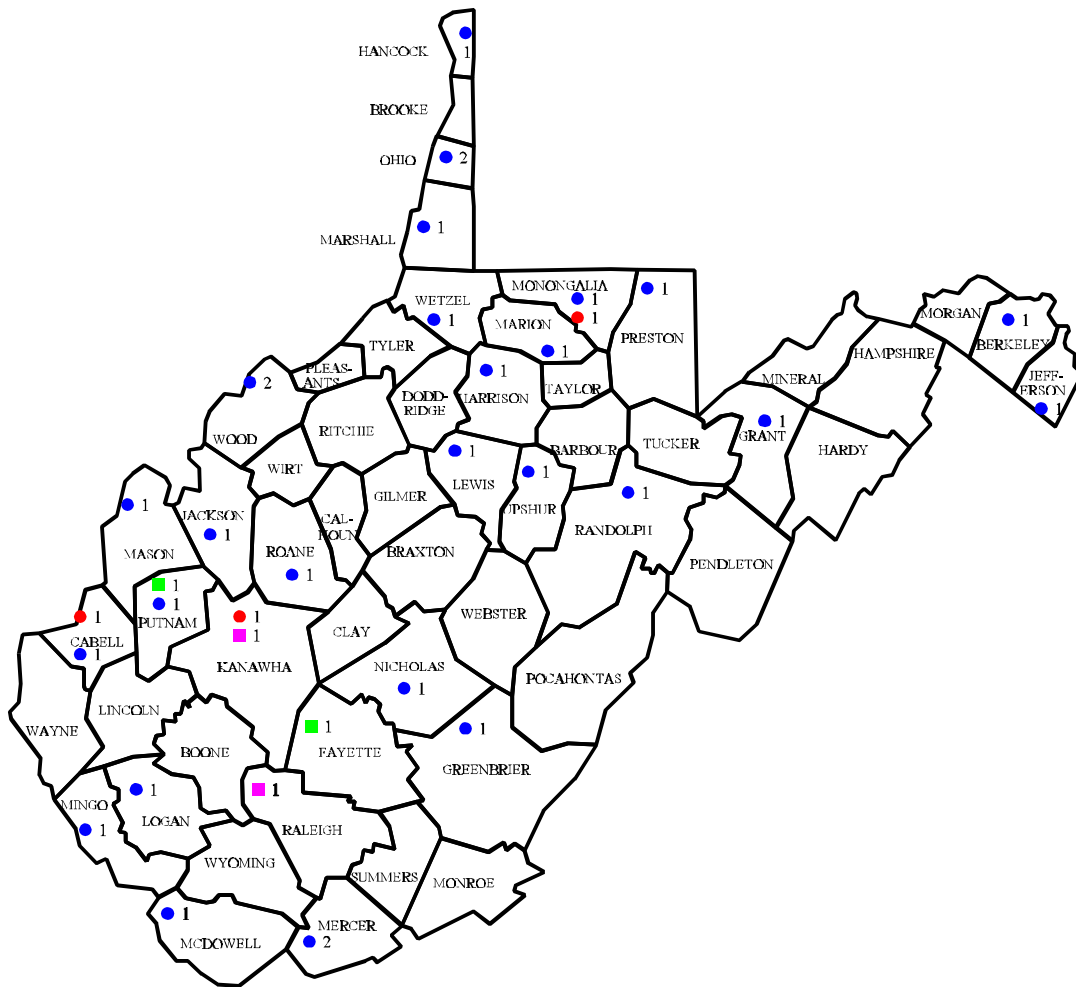
3.1.2.2 and 3.1.2.3 DIRECT AND ENABLING SERVICES

As portrayed in the description of the state and its people, direct health care programs face a myriad of financial, transportation and socially-derived obstacles in West Virginia. There are health professional shortages portrayed in 3.1.2.1 by specialty type; a maldistribution of existing medical providers; counties within the state that lack birthing facilities; counties in which primary care providers serving pediatric populations are at patient/provider capacity, and the list goes on and on.

Perinatal Health

To further depict the “state of the state,” a series of graphics follow – West Virginia birthing facilities (34 in number), availability of prenatal providers by medical specialty, and a listing of the number of prenatal providers by county and location.

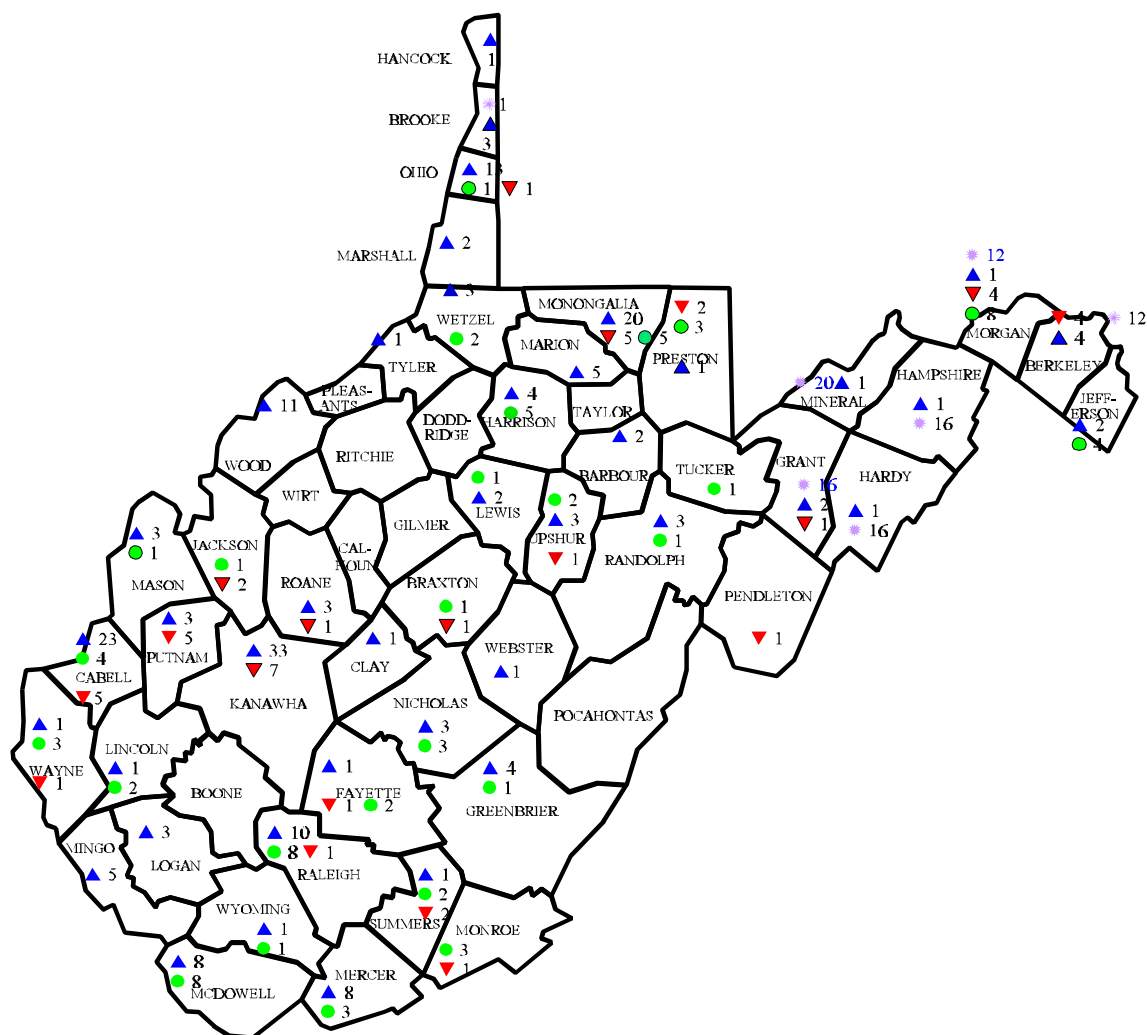
WEST VIRGINIA BIRTHING FACILITIES



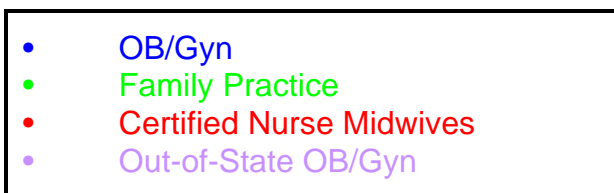
WVDHHR/BPH/OMCH/RFTS-MS/05-00



WEST VIRGINIA OBSTETRICAL PROVIDERS BY PROVIDER TYPE



WVDHHR/BPH/OMCH/WS/RFTS-MS/03-00



**WEST VIRGINIA PROVIDERS OF PRENATAL CARE
BY COUNTY AND PROVIDER TYPE**

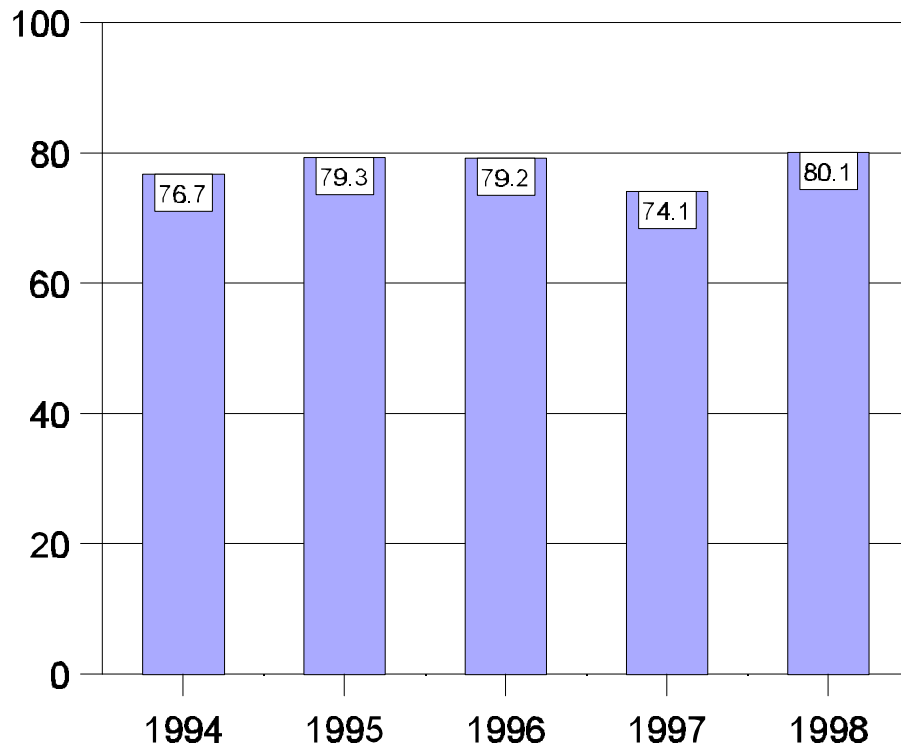
COUNTY NAME	NUMBER OF OB/GYN PHYSICIANS	NUMBER OF FAMILY PRACTICE PHYSICIANS PROVIDING PRENATAL CARE	NUMBER OF NURSE MIDWIVES
BARBOUR	2	0	0
BERKELEY **12	4	0	4
BOONE	0	0	0
BRAXTON	0	1	1
BROOKE **1	3	0	0
CABELL	23	4	5
CALHOUN	0	0	0
CLAY	1	0	0
DODDRIDGE	0	0	0
FAYETTE	1	2	1
GILMER	0	0	1
GRANT **16	2	0	1
GREENBRIER	4	1	0
HAMPSHIRE **16	1	0	0
HANCOCK	1	0	0
HARDY **16	1	0	0
HARRISON	4	5	0
JACKSON	0	1	2
JEFFERSON	2	4	0
KANAWHA	33	0	7
LEWIS	2	1	0
LINCOLN	1	2	0
LOGAN	3	0	0
MARION	5	0	0
MARSHALL	2	0	0
MASON	3	1	0
MERCER	8	3	0
MINERAL **20	1	0	0
MINGO	5	0	0

COUNTY NAME	NUMBER OF OB/GYN PHYSICIANS	NUMBER OF FAMILY PRACTICE PHYSICIANS PROVIDING PRENATAL CARE	NUMBER OF NURSE MIDWIVES
MONONGALIA	20	5	5
MONROE	0	3	1
MORGAN **12	1	8	4
MCDOWELL	8	8	0
NICHOLAS	3	3	0
OHIO	13	1	1
PENDLETON	0	0	1
PLEASANTS	0	0	0
POCOHONTAS	0	0	0
PRESTON	1	3	2
PUTNAM	3	0	5
RALEIGH	10	8	1
RANDOLPH	3	1	0
RITCHIE	0	0	0
ROANE	3	0	1
SUMMERS	1	2	2
TAYLOR	0	0	0
TUCKER	0	1	0
TYLER	1	0	0
UPSHUR	3	2	1
WAYNE	1	3	1
WEBSTER	1	0	0
WETZEL	3	2	0
WIRT	0	0	0
WOOD	11	0	0
WYOMING	1	1	0

** Out of State providers that come into West Virginia to provide prenatal care to WV residents.

In spite of the maldistribution of medical providers serving pregnant women, the state has experienced an increase in first trimester care across all payor groups, including Medicaid sponsored patients. Pregnant Medicaid cardholders accessing first trimester prenatal care was at 74.4%.

EARLY PRENATAL CARE
Percent of Pregnant Women Who Received First Trimester Care

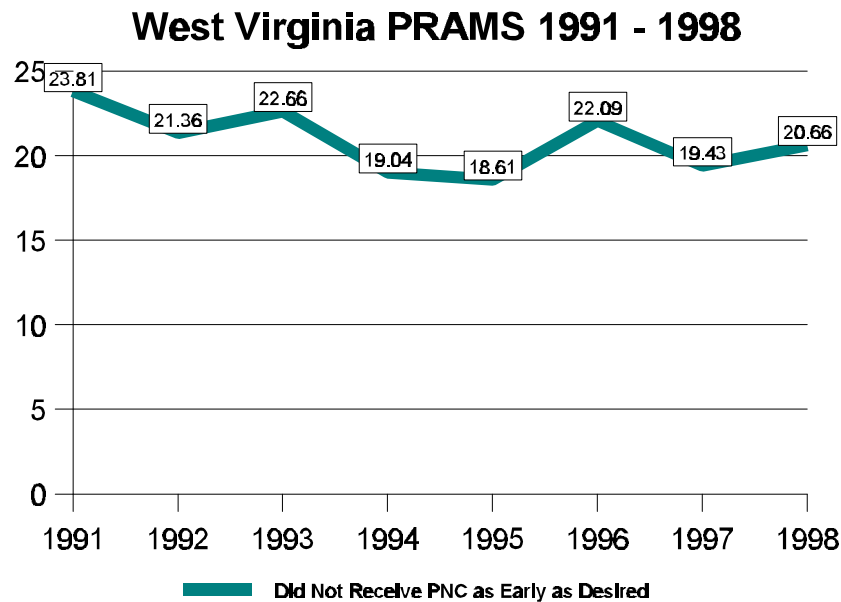


Source: WV Statistics Center
Epidemiology and Health Promotion - Bureau for Public Health
April, 2000

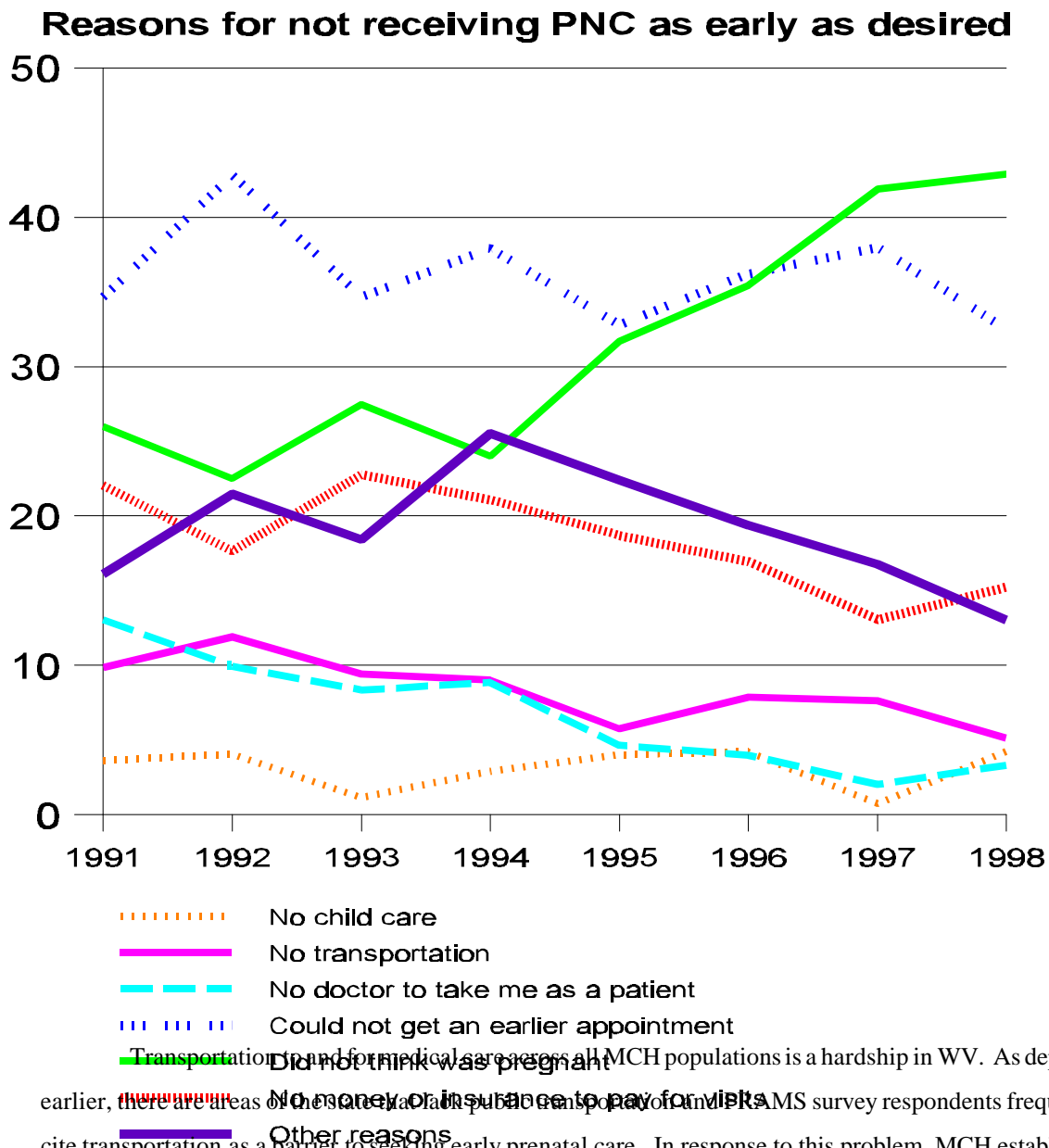
Historically, MCH has used the West Virginia Pregnancy Risk Assessment Monitoring System (PRAMS), a population-based surveillance system of maternal behaviors and experiences before and during a woman's pregnancy and during the early infancy of the child, to assist us with planning programs and community interventions. The PRAMS Survey is located in Appendix N. The PRAMS project is an integral component of the Office of Maternal and Child Health's Division of Research, Evaluation and Planning. Data and information gathered by the Project are used by the West Virginia Bureau for Public Health as a resource for both the development of maternal and child health programs and for evaluating the new and existing programs and projects. As one of the original PRAMS states, West Virginia implemented the project in 1988.

West Virginia PRAMS has been funded through cooperative agreements with the Centers for Disease Control and Prevention since that time. PRAMS supplements data from vital records for planning and assessing perinatal health programs on a state level. Because PRAMS data are population-based, findings from data analyses can be generalized to the entire state's population of women delivering live infants. PRAMS is designed not only to generate state-specific data but also to allow comparisons among states through standardized data collection methods. Findings from PRAMS analyses have been used to enhance the state's understanding of maternal behaviors and experiences and their relationship to adverse pregnancy outcomes. West Virginia PRAMS draws a stratified random sample of birth certificate records from women who have recently delivered a live-born infant. PRAMS staff collect data through statewide mailings that are followed up with telephone calls for non-respondents.

The following table describes the percent of women delivering a live born infant during the years of 1991-1998 who did not receive prenatal care as early as they desired during their pregnancy.



Of those women delivering a live born infant during the years of 1991-1998 and not receiving prenatal care as early as desired during their pregnancy, the following table lists the reasons reported for not receiving prenatal care as early as desired.



Transportation cost for medical care across all MCH populations is a hardship in WV. As depicted earlier, there are areas of the state that lack public transportation and where MCHMS survey respondents frequently cite transportation as a barrier to seeking early prenatal care. In response to this problem, MCH established in 1992 a community-based transportation assistance sites where monies can be obtained by pregnant women or families with infants to defray transportation cost for travel to medical care. If the patient is Medicaid sponsored, NEMT subsequently reimburses the local provider – keeping a constant flow of fiscal resources available to the community. The important point is that unlike NEMT, ART monies are provided in advance of the treatment. This project is made possible by strong collaboration with the Bureau for Children and Families which administers NEMT and funds originally provided by the Benedum Foundation.

Access to Rural Transportation (ART) Patient Utilization 1999				
Region	Number of Women Served	Number of Infants Served	Medicaid	Title V
I	1,299	512	1,787	24
II	725	293	1,018	
III	1,235	383	1,618	
IV	1,307	322	1,618	11
V	1,196	543	1,721	18
VI	669	182	842	9
VII	2,547	717	3,222	42
VIII	700	173	870	3
Misc.*	12	4	16	
TOTAL	9,690	3,129	12,712	107

Region I: McDowell, Mercer, Monroe, Raleigh, Summers, and Wyoming
 Region II: Cabell, Lincoln, Logan, Mason, Mingo, and Wayne
 Region III: Boone, Clay, Kanawha and Putnam
 Region IV: Braxton, Fayette, Greenbrier, Nicholas, Pocahontas, and Webster
 Region V: Calhoun, Jackson, Pleasants, Ritchie, Roane, Wirt, and Wood
 Region VI: Brooke, Hancock, Marshall, Ohio, Tyler and Wetzel
 Region VII: Barbour, Doddridge, Gilmer, Harrison, Lewis, Marion, Monongalia, Preston, Randolph, Taylor, Tucker, and Upshur
 Region VIII: Berkeley, Grant, Hampshire, Hardy, Jefferson, Mineral, Morgan, and Pendleton
 Miscellaneous: Various providers serving multiple counties – data not provided county-specific.

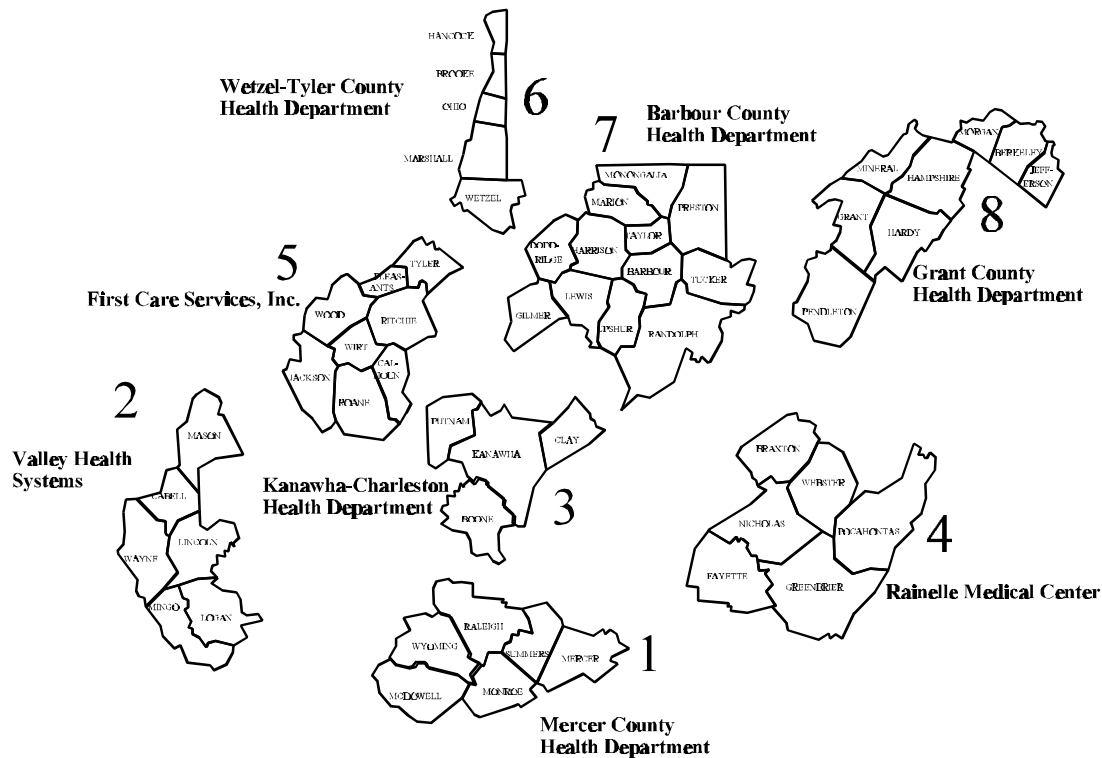
The mission of the Right From The Start (RFTS) initiative is to identify and implement a broad range of community-based strategies and interventions to reduce infant mortality and low birthweight rates among high risk populations. RFTS focuses the power of coordination and collaboration on combating infant mortality in West Virginia.

RFTS services are regionally administered by organizations that mobilize resources throughout the assigned catchment area to address the unique needs of the community and its people. RFTS regional lead agency coordinators recruit medical practitioners to care for pregnant women, encourage patient risk assessment and scoring, and engage the medical practitioner in client identification.

The coordination of care for pregnant and parenting women and their families (newborns) is a

cornerstone of RFTS. Relying on direct relationships between designated care coordinators and families, facilitates women’s access to and use of the perinatal health care and social services they need. Client empowerment is important; case managers realize that individualized needs assessments and service plans developed with the woman are more likely to be followed. The (designated) care coordinator’s on-going close contact with the family to coordinate care and services provides continuity that increases both client and provider satisfaction. The case management model used in West Virginia includes home visits, client assessment, health care coordination, and client education in parenting, infant care, family planning, and risk reduction behaviors such as smoking.

RFTS Regional Assignments



There are eight regional lead agencies who are responsible for day-to-day program operations, recruitment of care coordinators and their training, patient risk assessment, data reporting, etc.

RFTS regional lead agencies and their network of designated care coordinators reach out to locate and actively recruit pregnant and parenting women, especially women and their families who have been, or are in danger of being, underserved by the health and social service system. Strategies to recruit clients and facilitate service delivery include the following:

- Public presentations, including media
- Medical provider education and program recruitment
- Home visiting
- Distribution of flyers in community settings
- Referrals from positive pregnancy tracking
- Toll-free call follow-up – referred by state OMCH to community

Care management and other enabling services are provided to perinatal populations participating in the RFTS project. Enabling services have been developed to address needs identified by PRAMS data, an example of which is cited below:

Smoking Habits			
Year	Smoked 3 months before pregnancy	Smoked last 3 months of pregnancy	Smokes now (after pregnancy)
1996	40.17%	28.03%	32.81%
1997	32.45%	23.89%	29.25%
1998	41.42%	27.67%	35.22%

Smoking three months before pregnancy:

Table 1 Maternal age by smoking habits (did smoke) three months before pregnancy				
Year	≤ 18 years of age	19-24 years	25-34 years	35 and older
1996	60.04%	49.70%	29.12%	35.66%
1997	50.86%	41.51%	23.05%	24.83%
1998	58.33%	53.37%	29.94%	28.60%

e.g. Of mothers ≤ 18 years of age, 60.04% smoked 3 months before pregnancy.

Table 2 Maternal education by smoking habits (did smoke) three months before pregnancy		
Year	≤ High school diploma	> High school diploma
1996	52.39%	19.48%
1997	41.75%	17.35%
1998	53.84%	21.10%

e.g. Of mothers with ≤ high school education, 52.39% smoked 3 months before pregnancy.

Table 3 WIC participation by smoking habits (did smoke) three months before pregnancy		
Year	No WIC	Yes WIC
1996	23.93%	52.44%
1997	19.58%	42.35%
1998	25.16%	53.38%

e.g. Of mothers not participating in WIC during pregnancy, 23.93% smoked 3 months before pregnancy.

Table 4 Birthweight by smoking habits (did smoke) three months before pregnancy		
Year	Low (<2500 grams)	Normal (>2500 grams)
1996	53.40%	39.13%
1997	45.07%	31.39%
1998	52.85%	40.51%

e.g. Of mothers delivering low birthweight infants, 53.40% smoked 3 months before pregnancy.

Table 5 Prenatal care paid by Medicaid by smoking habits (did smoke) three months before pregnancy		
Year	Other payor source	Paid by Medicaid
1996	21.00%	55.56%
1997	20.50%	42.97%
1998	25.03%	57.15%

e.g. Of mothers with prenatal care paid by source other than Medicaid, 21.00% smoked 3 months before pregnancy.

Table 6 Birthweight by smoking habits (did smoke) last three months of pregnancy		
Year	Low (<2500 grams)	Normal (>2500 grams)
1996	43.08%	26.84%
1997	34.49%	23.03%
1998	40.12%	26.65%

e.g. Of mothers delivering low birthweight infants, 43.08% smoked during last 3 months of pregnancy.

Smoking now (after pregnancy):

Table 7 Maternal age by smoking habits (smoke now, after pregnancy)				
Year	≤ 18 years of age	19-24 years	25-34 years	35 and older
1996	51.08%	38.58%	24.77%	30.13%
1997	44.11%	37.12%	21.34%	20.60%
1998	52.71%	44.60%	24.93%	24.44%

e.g. Of mothers ≤ 18 years of age, 51.08% smoke now, after pregnancy.

Table 8 Maternal education by smoking habits (smoke now, after pregnancy)		
Year	≤ High school diploma	> High school diploma
1996	43.07%	15.72%
1997	37.83%	15.10%
1998	47.01%	15.20%

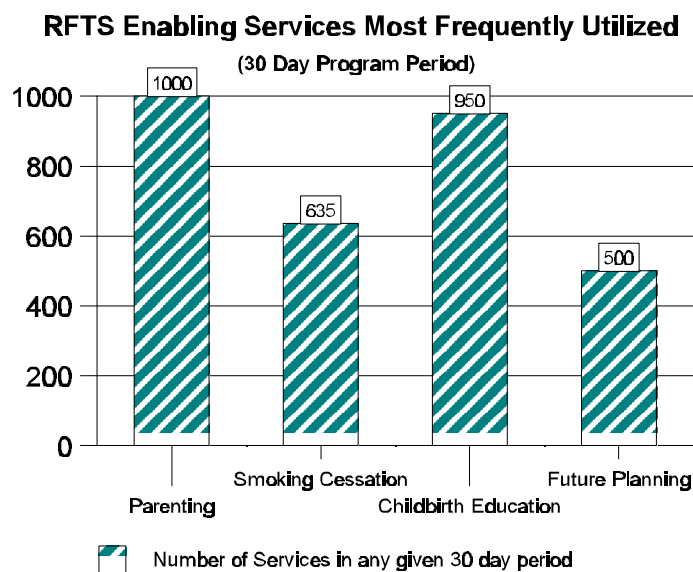
e.g. Of mothers with ≤ high school education, 43.07% smoke now, after pregnancy.

Table 9 Infants exposure to smoke by smoking habits (smoke now, after pregnancy)				
Year	No exposure	1 - 8 hours	9 - 23 hours	24 hour exposure
1996	24.16%	56.57%	83.05%	53.83%
1997	24.72%	43.25%	74.01%	66.37%
1998	27.99%	59.49%	79.17%	96.56%

e.g. Of mothers whose infants have no exposure to smoke, 24.16% smoke now, after pregnancy.

West Virginia has a targeted case management system that allows Medicaid and Title V perinatal populations to participate in RFTS. Patients electing to participate in RFTS begin receiving visits during pregnancy and continuing through their child's first birthday. The role of home visitors is to improve pregnancy outcomes, to promote children's health and development, and to strengthen families. In West Virginia these services are not universal but targeted to high need, vulnerable, low income persons.

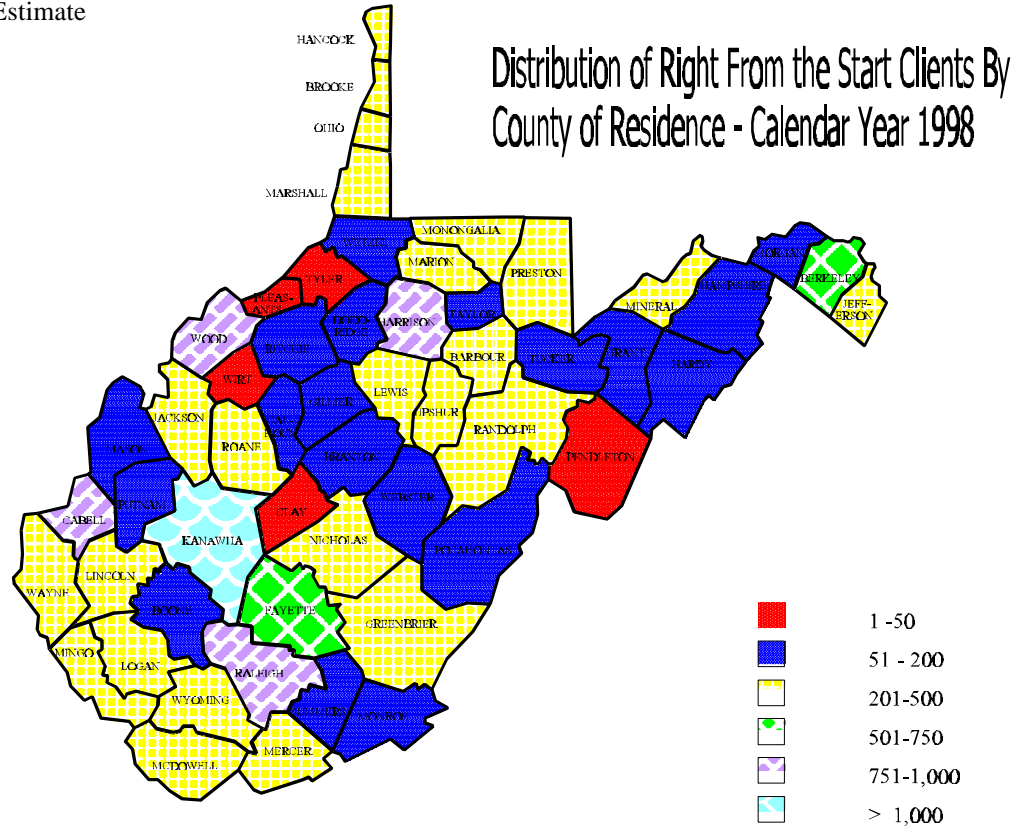
Parents learn parenting and other skills through the program, and it is intended that program participants would be better able to care for their children. RFTS often provides support to families identified by Child Welfare as "at risk." Community-based personnel providing RFTS help caregivers review their own child rearing histories and make decisions about how they wish to care for their children in light of the way they were cared for as children.



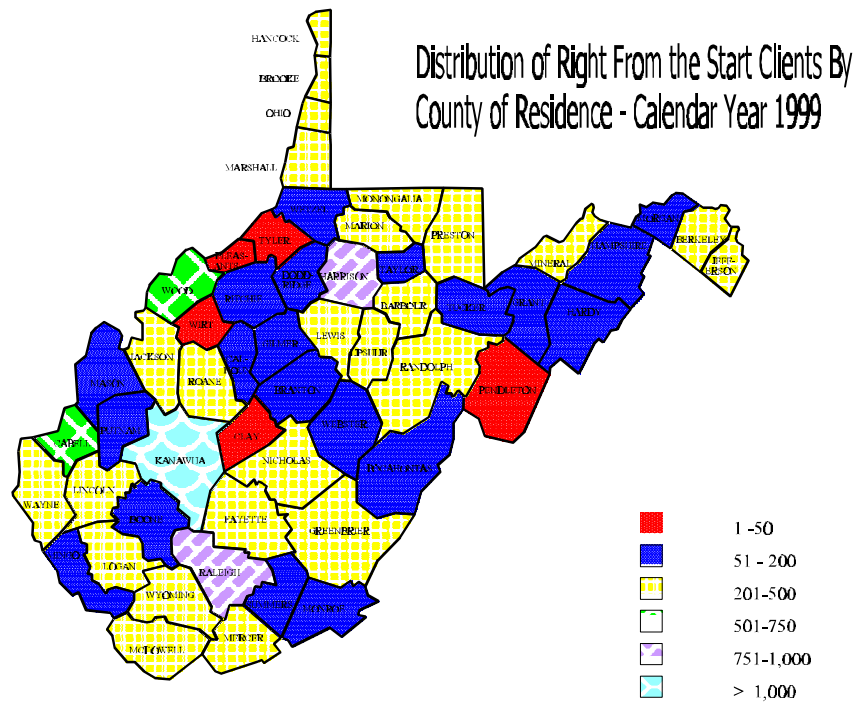
More and more West Virginia's pregnant women are participating in RFTS, some receiving a full complement of care management while others receive only enabling services, such as smoking cessation, childbirth education, or parenting.

RIGHT FROM THE START			
YEAR	TOTAL CLIENTS	# MOMS	# BABIES
1996	16,825	13,792	3,033
1997	17,212	14,282	2,930
1998	16,284	13,297	2,987
2000*	17,500	14,000	3,500

*Estimate



*Note: 2,752 clients -counties unknown



*Note: 1,143 clients -counties unknown

Financial barriers affecting perinatal population services include: a) decision by Medicaid to decrease the reimbursement schedule under RFTS/targeted case management, and b) to decrease reimbursement for completion of Pregnancy Risk Scoring Instrument (PRSI), which serves as the tool for early identification of high risk perinatal populations. These reductions in units of service reimbursement under care management for perinatal populations has resulted in community-based providers discontinuing the service. The decrease in reimbursement for completion of the PRSI, \$125.00 to \$8.00, met with much medical disapproval, and resulted in fewer prenatal patients receiving risk screening.

Child Populations

Direct health service in West Virginia continues to pose a challenge. The number of children without health coverage is at 12%, although this figure reflects pre-CHIP eligibility expansion to 200% of the Federal Poverty Level. We have also seen a 25% increase in the number of Medicaid children eligible for EPSDT. While it is a boon to children and families to have health care coverage, the system of care is laboring to assure access.

EPSDT ELIGIBLES/PARTICIPANT DATA (1995 - 1999)		
Fiscal Year	Total Eligibles	Eligibles Participating
1995	171,091	61%
1996	170,661	49%
1997	183,588	44%
1998	180,839	74%
1999	202,917	53.7%

Source: HCFA 416 for 1995 - 1999

Pediatric health provider-patient ratios vary across the state, with Lincoln County at 2193:1, Roane County at 2881:1, as compared to Kanawha County at 296:1. The availability of pediatric health care in Kanawha County is largely attributed to the CAMC-WVU pediatric residency program location at the state capitol. **Maldistribution of medical providers serving children of all income groups is a problem.**

Given the challenge to health care access, WV has established a network of school-based clinics linked to community health centers who administer care in school settings. These arrangements have improved health care access for children as depicted in the following chart of activity and report.

WV School-Based Health Center Initiative Report Period: 7/01/99 - 12/31/99 (Second Quarter)	
Enrollment	<p>15,154 (65%) students who attend schools with a school-based health center are enrolled – they have returned a signed parental consent form. The <u>65% figure is the highest enrollment rate ever</u> in the six years of the WV School-Based Health Center Initiative.</p> <p>The number of enrollees was <u>2% higher</u> than it was last year after two quarters.</p>
Users	<p>The school-based health centers reported a <u>1% increase</u> in the number of school-based health center users over the same period last year.</p> <p>7,346 students, 32% of the student population at school-based health center schools, have already used school-based health center services on at least one occasion. At this point last year, the figure was 29%.</p>
Visits	<p>For the first two quarters, the number of all school-based health center visits (20,049) is <u>up by 23%</u> over the same period last year.</p> <p>The number of medical visits is <u>up by 6%</u>.</p> <p>Visits to a mental health counselor (1,249) <u>jumped by 37%</u> compared to the same period last year.</p> <p>Visits to a school-based health center dentist were <u>down 27%</u> compared to the same period last year.</p> <p>Visits to a school-based health center nurse <u>increased by 29%</u> compared to the same period last year.</p> <p>The visits by provider breakdown is: 53% nurse practitioner/physician assistant; 33% school-based health center nurse; 9% school-based health center mental health counselor; 2% physician; <1% dentist; and 2% other (medical assistant and dietician).</p>
Referrals	<p>The completed referral rate was 81% for all outside referrals, and 53% for referrals back to the school-based health center. Please keep in mind that many of the referrals are not completed until later in the year.</p>
Preventive Health	<p>The number of well child exams and sports physicals provided is <u>down 21%</u>.</p> <p>26% of all medical diagnoses were for preventive health services (e.g., well child exam, sports physical, immunizations, etc.). The figure compares to 28% at this point last year.</p>
Mental Health	<p>The number of mental health users and visits is <u>up 20% and 41%</u> respectively over the same period last year. The average number of visits per mental health user was 3.1.</p>

WV School-Based Health Center Data Summary - 1999-00 School Year (7/1/99-12/31/99) - Year 6

School Characteristics														BMC	CCMC	CCPC	COGMC	CWSH	EAHHC	HFF	LPC	MHHCC	MVA	NRHA	PCC	RCPC	RMC	RWC	AVG
Total Student Population														800	1,087	1,709	1,234	4,952	2,174	1,164	602	1,206	2,009	1,228	711	944	951	827	1,438
High School														X	X	X	X	XXX	XX	X	X	X	XX	X	X	X	XX	X	X
Middle/Jr. High School															X				XX	X		X				X		X	
Elementary School																X	X		X	X		X		X			X		
Consent Rate																													
# of Students Enrolled														578	392	1,114	787	3,538	1,695	723	533	1,008	987	857	383	930	535	766	1,058
% of Students Enrolled														72%	36%	65%	66%	63%	78%	82%	89%	58%	49%	71%	54%	99%	56%	95%	74%
SBHC Utilization																													
SBHC Users														279	105	659	261	1,834	886	361	270	552	350	589	182	559	209	490	515
% of Enrollees Using SBHC														48%	27%	59%	33%	43%	51%	50%	51%	55%	35%	66%	48%	60%	39%	62%	49%
SBHC Users/Total Student Pop.														35%	9%	39%	22%	33%	40%	31%	45%	46%	17%	46%	28%	60%	22%	60%	38%
# of Visits (All) per User														1.6	1.8	1.8	0.8	1.7	1.8	1.1	2.4	2.3	2.1	3.1	1.6	2.2	1.6	2.0	2
Encounters																													
# of Medical														252	193	907	141	721	1,011	384	264	795	136	948	212	474	178	785	493
# of Dental														NP	NP	NP	NP	NP	NP	NP	NP	NP	NP	3	NP	NP	NP	46	25
Dental Users														NP	NP	NP	NP	NP	NP	NP	NP	NP	8	NP	NP	NP	NP	144	76
# of Visits per User														NP	NP	NP	NP	NP	NP	NP	NP	NP	0.4	NP	NP	NP	NP	1.3	0.3
# of Mental Health														ND	NP	NP	NP	177	459	0	47	103	100	438	NP	NO	NP	18	168
Mental Health Users														ND	NP	NP	NP	62	128	0	27	32	51	108	NP	ND	NP	31	54
# of Visits per User														ND	NP	NP	NP	2.9	3.8	0.0	1.7	3.2	2.0	4.1	NP	ND	NP	0.6	3.1
# of Nurse & Medical Assistant														183	0	303	23	1,914	52	4	387	358	511	366	73	787	163	127	375

WV School-Based Health Center Data Summary - 1999-00 School Year (7/1/99-12/31/99) - Year 6

Well Child & Sports Physicals		BMC	CCMC	CCPC	COGMC	CWSHI	EAHHC	HFF	LPC	MHHCC	MVA	NRHA	PCC	RCPC	RMC	RWC	AVG
# Well Childs/Sports P.E.		38	28	99	48	165	30	72	42	27	18	141	25	45	29	103	81
% Users Getting an Exam		14%	25%	15%	18%	10%	3%	20%	16%	5%	5%	25%	14%	8%	14%	21%	12%
Well Child & Sports Physicals at Non-SBHC Schools																	
Emotional		1%	3%	2%	0%	2%	5%	0%	0%	1%	22%	2%	1%	0%	0%	1%	3%
Health Supervision		19%	36%	21%	55%	27%	24%	36%	14%	25%	24%	31%	32%	9%	49%	25%	26%
Injuries		8%	10%	14%	3%	7%	11%	8%	17%	11%	8%	10%	8%	11%	5%	11%	9%
Respiratory		14%	13%	14%	20%	11%	13%	27%	23%	20%	12%	12%	11%	22%	22%	20%	18%
Skin		3%	3%	18%	5%	4%	4%	3%	2%	7%	0%	5%	8%	4%	2%	7%	5%
Symptoms		27%	12%	17%	3%	33%	18%	3%	32%	19%	20%	11%	6%	29%	6%	19%	18%
Other		27%	23%	14%	14%	16%	25%	25%	12%	17%	16%	29%	34%	25%	16%	17%	21%
Types of Services																	
Acute Care		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
EPSDT		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Sports Physicals		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Case Management		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Laboratory		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Dental Services												X				X	
Mental Health Counseling		X				X	X	X	X	X	X	X		X		X	
Opening Date of 1 st SBHC																	
Opening Date of 1 st SBHC		9/93	9/98	9/95	4/96	9/94	4/93	10/96	9/95	9/96	1/95	1/94	9/90	1/95	9/97	3/95	

WV School-Based Health Center Data Summary - 1999-00 School Year (7/1/99-12/31/99) - Year 6

Staff	BMC	CCMC	CCPC	COGMC	CWSHI	EAHHC	HFF	LPC	MIHCC	MVA	NRHA	PCC	RCPC	RMC	RWC	AVG
Medical FTE	0.05	0.02	0.00	0.09	0.10	0.00	0.10	0.10	0.20	0.10	0.20	0.20	0.10	0.02	0.05	
PA or NP FTE	0.50	0.50	1.50	0.80	2.50	1.00	2.00	0.75	1.20	1.00	1.00	0.30	0.70	0.50	1.00	
Psychosocial FTE	0.10	0.00	0.00	0.00	2.00	0.40	0.00	0.25	0.50	1.00	0.90	0.00	0.00	0.00	1.00	
Nurse FTE	1.00	0.00	1.50	0.08	2.50	1.00	0.00	0.75	1.00	2.00	1.00	0.30	1.00	0.50	1.00	
Dental FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.05	0.00	0.00	0.00	0.05	
Health Education FTE	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.00	
Care Coordinator FTE	1.00	0.50	1.50	0.08	2.50	1.00	2.00	1.10	1.00	0.00	2.00	0.20	1.00	0.60	1.00	
Encounters by Provider Type																
Physician	0%	0%	0%	1%	2%	0%	0%	1%	0%	0%	11%	25%	0%	0%	1%	3%
Nurse Pract./Physician Assistant	53%	100%	73%	88%	27%	66%	99%	41%	71%	20%	48%	51%	43%	59%	75%	58%
Counselor	0%	0%	0%	0%	5%	31%	1%	7%	8%	13%	21%	0%	0%	0%	0%	6%
Nurse	47%	0%	27%	12%	57%	3%	0%	50%	20%	65%	18%	9%	57%	41%	15%	28%
Psychiatrist	0%	0%	0%	0%	1%	0%	0%	0%	1%	0%	2%	0%	0%	0%	2%	4%
Dental/Medical Assist./Other	0%	0%	0%	0%	9%	0%	0%	0%	0%	0%	0%	15%	0%	0%	5%	2%
Outside Referrals																
All Referrals	17	11	25	1	28	3	15	37	5	3	107	11	9	1	79	23
Closed Referrals	13	5	19	1	17	23	13	32	0	2	63	8	7	1	74	19
cLOSED/aLL Referrals	76%	45%	78%	100%	65%	78%	87%	88%	0%	87%	59%	73%	78%	100%	94%	79%

WV School-Based Health Center Data Summary - 1999-00 School Year (7/1/99-12/31/99) - Year 6

All Visits by Coverage																
	BMC	CCMC	CCPC	COGMC	CWSHI	EAHHC	HFF	LPC	MHHCC	MVA	NRHA	PCC	RCPC	RMC	RWC	AVG
Medicaid	38%	44%	57%	38%	33%	20%	44%	80%	39%	28%	49%	49%	38%	38%	31%	40%
PHS	7%	3%	2%	8%	6%	3%	1%	1%	0%	0%	18%	10%	28%	1%	3%	6%
Private/Third Party	44%	38%	25%	45%	49%	55%	44%	28%	41%	54%	28%	31%	31%	38%	52%	40%
None/Self-Pay	12%	18%	14%	9%	12%	20%	8%	12%	19%	20%	5%	16%	6%	21%	12%	13%
CHIP	1%	1%	2%	0%	0%	1%	3%	3%	1%	0%	2%	1%	2%	3%	2%	1%

NA = Not Available, ND = Service is provided but data are not reported, NP = Services not provided

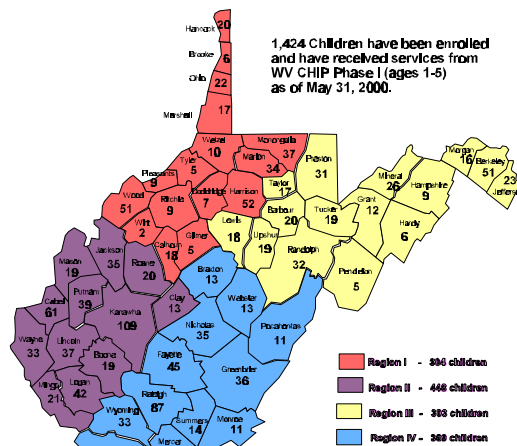
Site Key

BMC	Belington Medical Clinic (Phillip Barbour H.S.) - 1 Site
CCMC	Cabin Creek Medical Center (Clendenin M.S. and Herbert Hoover H.S.) - 2 Sites
CCPC	Clay County Primary Care (Clay E.S., Clay County M.S., and Clay County H.S.) - 3 Sites
COGMC	Camden-on-Gauley Medical Center (Glade Elementary and Webster County High School) - 2 Sites
CWSHI	Cabell-Wayne School Health Initiative (Cabell-Midland H.S., Huntington H.S., and Spring Valley H.S.) - 3 Sites
EAHHC	E.A. Hawse Health Center (E. Hardy Early, Middle & High Schools & Moorefield Elementary, Middle & High Schools) - 2 Sites
HFF	Hygeia Facilities Foundation (Sherman Elementary and Sherman Jr. and High Schools) - 2 Sites
LPC	Lincoln Primary Care (Guyan Valley H.S.) - 1 Site
MHHCC	Minnie Hamilton Health Care Center (Pleasant Hill Elementary and Calhoun M.S. and Calhoun H.S.) - 2 Sites
MVA	Monongahela Valley Association (East Fairmont H.S. & North Marion H.S.) - 2 Sites
NRHA	New River Health Association (Collins M.S., Mt. Hope M.S., and Mt. Hope H.S.) - 3 Sites
PCC	Pendleton Community Care (North Fork Elementary School and Pendleton County High School) - 2 Sites
RCPC	Richie County Primary Care Association (Richie County Middle and High Schools) - 1 Site
RMC	Rainelle Medical Center (Greenbrier West H.S. and Meadow Bridge Elementary and Meadow Bridge H.S.) - 3 Sites
RWC	Richwood Wellness Center (Richwood Jr. and Sr. High Schools) - 1 Site

The state's Child Health Insurance Program (CHIP) is an opportunity for meeting the multiple and complex health needs facing low income, uninsured children, including adolescents. The program is intended to diminish financial barriers to care, thus improving access for children and adolescents to help ensure the state's children achieve full potential as healthy, productive adults. The availability of financing, whether public or private, does not guarantee that children and youth will actually receive services that can assure their overall health.

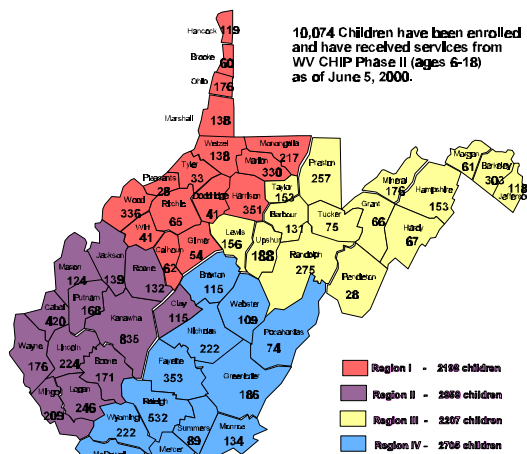
West Virginia CHIP covers a full range of health services including dentistry. Partnership arrangements have been made for adolescents to receive confidential services for contraceptive care, when appropriate, under Title X or otherwise through CHIP's provider network. Special accommodations are also made for pregnant teen referral into public health programming and care management systems like RFTS. CHIP enrollments to date are portrayed below.

West Virginia Department of Health and Human Resources
WV Children's Health Insurance Program (WV CHIP)



Source: WV Department of Health and Human Resources
Date: May 31, 2000

West Virginia Department of Health and Human Resources
WV Children's Health Insurance Program (WV CHIP)



Source: WV Department of Health and Human Resources
Date: June 5, 2000

Medicaid Managed Care (MMC) has not improved pediatric health care access as reflected on the previous chart. As a matter of fact, the number of EPSDT screenings, under MMC, dropped in FY 99, in part due to the closure of one health maintenance organization.

MCH made multiple overtures to MMC organizations offering our medical credentialing services; access to existing MCH recruited provider networks; and field program staff who provide direct technical assistance to the medical community serving maternal and child health populations. While multiple meetings occurred, efforts at “partnering” have been limited to EPSDT/Pediatric staff providing intermittent training, en masse, to network providers on a regional basis with the educating confined to EPSDT screening components.

Adolescence, roughly from the ages of ten to fifteen, mark the end of childhood and open up new vistas of the future – of options and goals. All adolescents are at a cross road: these crucial years offer an opportunity to transform a period of high risk into satisfaction and pride.

Responsible attention to adolescents includes teaching of life skills through role-modeling, adult guidance and encouragement to help them succeed in school. The Office of Maternal and Child Health Adolescent Health Coordinators, located throughout the state, offer community programs that have been developed to assist young people in responding to problems they confront, particularly how to resist tobacco, alcohol and drugs; life skills training with special attention to decision making and conflict resolution; serve as motivation and support to adults including family and youth organizations to improve parent-child communication and to involve school health centers in health prevention and disease prevention activities.

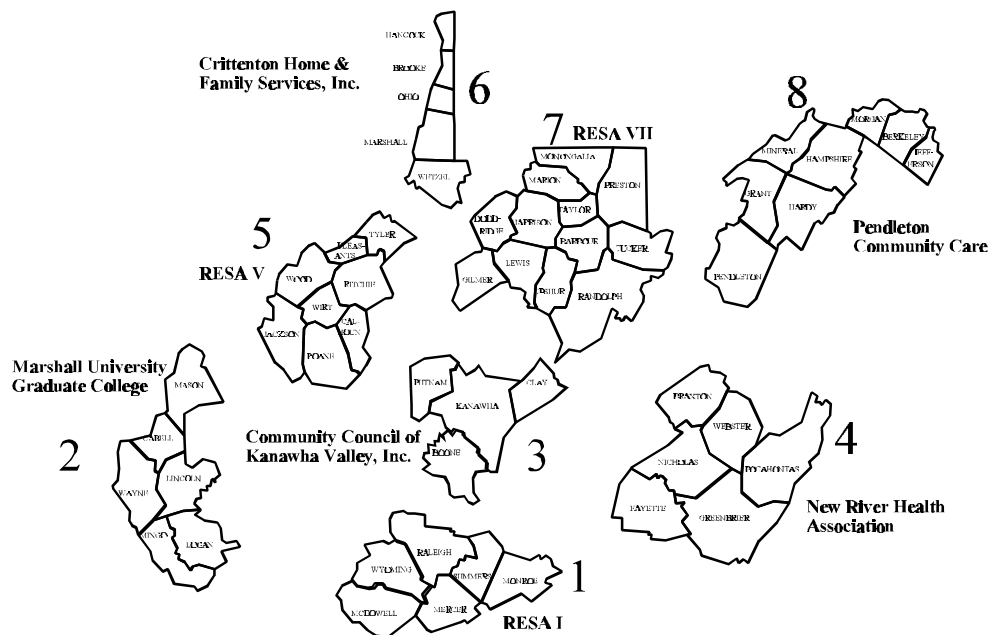
School Population Distribution by Region

	*STUDENT POPULATION	SQUARE MILES	STUDENTS PER MILE	NUMBER OF SCHOOLS
RESA I	40,791	2,954	13.8	78
RESA II	46,172	2,568	18.0	91
RESA III	48,896	2,118	23.1	94
RESA IV	26,413	4,369	6.1	58
RESA V	31,029	2,705	11.5	46
RESA VI	25,267	968	26.1	42
RESA VII	59,166	5,160	11.5	104
RESA VIII	33,927	3,493	9.7	59

*Second Month Public School Enrollment 1994-95

Source: West Virginia Department of Education/Sourcebook '95.

Adolescent Health Regions



Health care utilization among adolescents 10 to 14 years continue to be problematic. A review of the HCFA-416 reflects that while 52,877 children in this age group were eligible for EPSDT screens, only 14,023 were actually screened. Also, the number of WV adolescents enrolled in CHIP continues to be disproportionately low.

The Adolescent Health Initiative (AHI) staff are supported with Title V monies but physically housed and hired by community-based partnership organizations. Each year this team provides instruction opportunities for more than 15,000 persons through schools, civic organizations, churches, etc. One focus of the Adolescent Health Coordinators is to work with adolescents to reduce risk behaviors including school dropout. School counselors often identify children who are at risk of disengagement from school and this targeted group receive special attention. The WV medical community is encouraged to screen youth for “behavioral conditions” that may affect school performance/attendance and general well-being.

A high school dropout is one who leaves high school before graduation without transferring to another school. Children who do not complete high school are more likely to have health, economic, and social problems. High school dropouts are less likely than high school graduates to find employment and have less earning potential than graduates.

Students who leave school say the reason is their poor academic performance. Higher rates of dropouts occur for schools that lack an “early warning” mechanism , like that cited above, where the counselors are on the alert.

There are few direct attempts to prevent dropouts before the youth is at risk. Last ditch intervention efforts are very intensive and costly. Given the high rates of dropouts and the great loss it represents, it is worthwhile to invest in prevention programs that identify children at risk in early childhood and provide high quality educational programs to them. (University of Pittsburgh Office of Child Development, Robert B. McCall)

The number of high school dropouts in West Virginia in 1997 was 3,954 or 16.5 percent of the students in grades 7 through 12. **In 1997, one out of six seventh through twelfth grade students dropped out of high school.** This is a .9 percent improvement over the 1990 rate of 16.7 percent of 4,243 dropouts.

Marion County made the greatest improvement, lowering its dropout rate from 25.9 in 1980 to 6.6 in 1997. The county with the least improvement was Wyoming, which increased from 6.5 percent in 1990 to 16.4 percent in 1997. The county with the highest percent of high school dropouts is Jefferson with a very high 25.9 percent. **The Office of Maternal and Child Health, Adolescent Health Initiative, engages communities and schools in activities designed to keep youth in school. Several educational modules/programs have been developed for this purpose, including “Helping Young Moms Stay in School” which uses donations to defray the cost of expenses for low income young persons to participate in after school and/or school events.**

Adolescent Health Coordinators are active in the “Keep a Child in School” program which recruits community volunteers to serve as mentors of at risk youth. A study published in the April 2000 issue of the Archives of Pediatric and Adolescent medicine shows a strong positive relationship between an adolescent having an adult mentor and decreased participation in smoking, drug use, and sexual practice. West Virginia health data which references critical objectives for adolescents and young adults based on 2010 objectives, are located on page 136.

1999 WEST VIRGINIA DATA

Unintentional and Intentional Injuries

20.7%	Rarely or never wear safety belts
31.3%	Rode with a drinking driver during the past month
21.5%	Carried a weapon during the past month
33.1%	Were in a physical fight during the past month
7.9%	Attempted suicide during the past year

Alcohol and Other Drug Use

48.6%	Drank alcohol during the past month
35.5%	Reported episodic heavy drinking during the past month
29.3%	Used marijuana during the past month
3.2%	Ever injected illegal drugs
20.4%	Ever sniffed or inhaled intoxicating substances

Sexual Behaviors

54.8%	Ever had sexual intercourse
18.6%	Ever had four or more sex partners
40.4%	Had sexual intercourse during the past three months
57.5%	Did not use a condom during last sexual intercourse
79.5%	Did not use birth control pills during last sexual intercourse

Tobacco Use

74.7%	Ever smoked cigarettes
42.2%	Smoked cigarettes on 20 or more days during the past month
24%	Smoked cigarettes on 20 or more days during the past month
15.7%	Used smokeless tobacco during the past month*
35%	Not asked proof of age for purchase of cigarettes

Dietary Behaviors

20.4%	Ate <5 servings of fruits and vegetables yesterday
34.7%	Thought they were overweight
47%	Were attempting weight loss
5.1%	Took laxatives or vomited to lose or maintain weight during the past month

Physical Activity

37%	Did not participate in vigorous physical activity
74%	Did not participate in moderate physical activity
15.4%	Were not enrolled in physical education class**
69.3%	Did not attend physical education classes daily**
N/A	Exercised <20 minutes in an average physical education class

* 15.7% Total 28.6% of males on smokeless tobacco

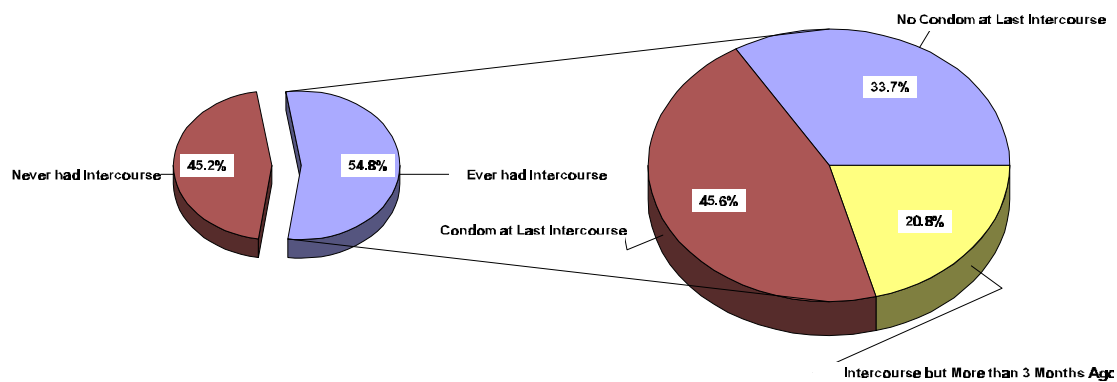
** Only 1 credit of physical education is required for high school students, usually 9th & 10th grades (data reflects such)

CRITICAL OBJECTIVES FOR ADOLESCENTS AND YOUNG ADULTS

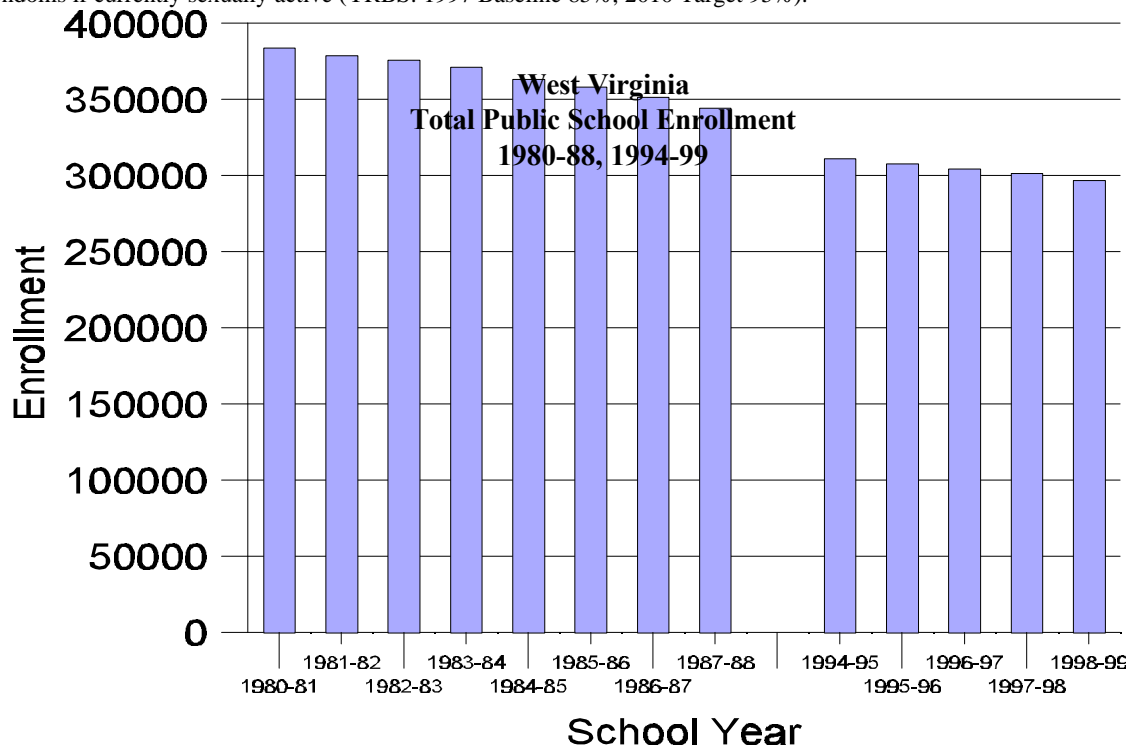
*Critical health outcomes are underlined, behaviors that substantially contribute to important health outcomes are in normal font, and Leading Health Indicators are in **bold face font**.*

Obj. #	Objective	Baseline (year)	2010 Target
<u>16-03</u>	<u>Reduce deaths of adolescents and young adults</u> - 10 to 14 year olds - 15 to 19 year olds - 20 to 24 year olds	22.6 per 100,000 (1998) 81.0 per 100,000 (1998) 89.7 per 100,000 (1998)	16.6 per 100,000 43.2 per 100,000 57.3 per 100,000
<u>15-15</u>	<u>Reduce deaths caused by motor vehicle crashes.</u>	26.1 per 100,000 (1998)	(1)
<u>26-01</u>	<u>Reduce deaths caused by alcohol and drug-related motor vehicle crashes/</u>		(1)
15-19	Increase use of safety belts.	79.3% (1999)	(1)

Obj. #	Objective	Baseline (year)	2010 Target
26-06	Reduce the proportion of adolescents who report that they rode, during the previous 30 days, with a driver who had been drinking alcohol.	31.3% (1999)	30%
<u>18-01</u>	<u>Reduce the suicide rate - 18 & under.</u>	3.1 per 100,000 (1998)	(2)
18-02	Reduce the rate of suicide attempts by adolescents.	7.9% (1999)	1.0%
<u>15-32</u>	<u>Reduce homicides.</u> - 10 to 14 year olds - 15 to 19 year olds	1.5 per 100,000 (1997) 13.5 per 100,000 (1997)	(1) (1)
15-38	Reduce physical fighting among adolescents.	33.1% (1999)	33.3%
15-39	Reduce weapon carrying by adolescents on school property.	9.8% (1999)	8%
26-11	Reduce the proportion of persons engaging in binge drinking of alcoholic beverages.	8.3% (1997)	3.0%
26-10	Reduce past-month use of illicit substances.	9.4% (1997)	0.7%
06-02	Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed.	(3)	(3)
<u>09-07</u>	<u>Reduce pregnancies among adolescent females 18 and under.</u>	16.7 per 1,000 females (1998)	46 per 1,000
<u>13-05</u>	<u>(Developmental) Reduce the number of cases of HIV infection among adolescents and adults.</u>	(4)	(4)
<u>25-01</u>	<u>Reduce the proportion of adolescents and young adults with Chlamydia trachomatis infections.</u> - females attending FP clinics - females attending STD clinics - males attending STD clinics	5.0% (1997) 12.2% (1997) 15.7% (1997)	3.0% 3.0% 3.0%
25-11	Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active.	85% (1999)	95%
27-02	Reduce tobacco use by adolescents.	57.1% (1999)	21%
<u>19-03</u>	<u>Reduce the proportion of children and adolescents who are overweight or obese.</u>	10% (1999)	5%
22-07	Increase the proportion of adolescents who engage in vigorous physical activity that promotes cardiorespiratory fitness 3 or more days per week for 20 or more minutes per occasion.	62.4% (1999)	85%
27-02	Percentage of students who are not current smokers - used 30 days prevalence question.	57.8%	



Objective 25-11 (Leading Health Indicator): Increase the proportion of adolescents who abstain from sexual intercourse or use condoms if currently sexually active (YRBS: 1997 Baseline 85%, 2010 Target 95%).



Source: WV Department of Education; Exceptional Students in West Virginia's County School Districts - FY 99
Adolescent Deaths

The teen violent death rate measures the rates of death for youths ages 15-19 from unintentional injuries, homicides or suicides. Unintentional injuries, such as auto accidents, are the leading cause of death. The actual number of teen violent deaths in many counties is very small, and this small sample distorts both rates and percent change.

One out of 1,680 teens 15-19 years old died due to a violent injury in 1997. This represents 84 deaths and is a death rate of 59.5 per 100,000 teens. **Over the last seven years, the teen violent death rate decreased from 77 in 1990 to 59.5 in 1997.**

Doddridge County had the lowest teen violent death rate in 1997. In 1997, Doddridge County had a teen injury death rate of 5.0. The county with the highest teen violent death rate in 1997 was Ritchie with a rate of 225.7. The least improved county was Summers. In 1990, Summers County's teen violent death rate was 40.0 and by 1997 it had risen to 172.4. **Because many of our counties are sparsely populated, the actual number of teen injury deaths is small, yet one death can impact the rate.**

A chart depicting firearm injury death for 1998 is listed below.

Types of Firearm Injury Deaths by Age Group and Gender West Virginia Residents, 1998											
Category	Age in Years										Total
	0-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65-74	75+	
Total											
Unintentional	0	1	0	1	0	0	1	1	0	1	5
Suicide	0	0	12	16	19	30	31	18	14	21	161
Homicide	0	2	3	10	13	17	7	1	5	2	60
Legal	0	0	0	0	0	3	0	0	0	0	3
Intervention	0	0	1	1	1	0	1	1	1	0	6
Undetermined	0	3	16	28	33	50	40	21	20	24	235
Total											
Male											
Unintentional	0	1	0	1	0	0	0	1	0	1	4
Suicide	0	0	10	15	15	24	28	18	14	18	142
Homicide	0	1	2	6	9	13	5	1	2	1	40
Legal	0	0	0	0	0	3	0	0	0	0	3
Intervention	0	0	1	0	1	0	1	1	1	0	5
Undetermined	0	2	13	22	25	40	34	21	17	20	194
Total											

Types of Firearm Injury Deaths by Age Group and Gender West Virginia Residents, 1998											
Category	Age in Years										Total
	0-9	10-14	15-19	20-24	25-34	35-44	45-54	55-64	65-74	75+	
Female											
Unintentional	0	0	0	0	0	0	1	0	0	0	1
Suicide	0	0	2	1	4	6	3	0	0	3	19
Homicide	0	1	1	4	4	4	2	0	3	1	20
Legal	0	0	0	0	0	0	0	0	0	0	0
Intervention	0	0	0	1	0	0	0	0	0	0	1
Undetermined	0	1	3	6	8	10	6	0	3	4	41
Total											

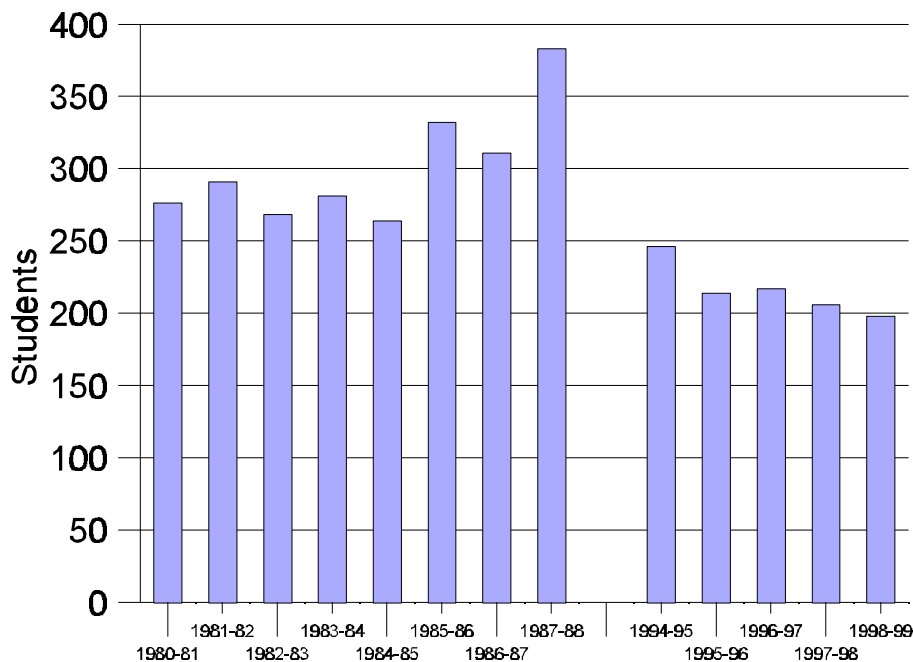
Children's Oral Health

Children's oral health will be discussed in greater detail in Section 3.1.2.4, but it is important to note that there are 811 licensed practicing dentists in the State of West Virginia. Of the 811 practicing, as of April 1, 2000, 526 will accept children that have Medicaid coverage. The HCFA-416 report for EPSDT activities in FY 99 states 62,334 children had, as a part of their comprehensive screen, an examination of the oral cavity but only 9,658 children received dental treatment. **Oral health care in West Virginia, like the rest of the nation, is poorly utilized by children with Medicaid coverage.**

Children with Special Health Care Needs

Identification of youngsters with or at risk of debilitating conditions is a priority in West Virginia. Multi-prong, population-based methodologies to identify this population will be described later in this grant. MCH relies on EPSDT as a major source of referral for Children's Specialty Care (CSC), the division which houses Birth to Three (Part C/IDEA); Single Point of Entry, which provides case management and referral to children/families ineligible for specialty care, ultimately linking them to alternative resources; and the Children with Special Health Care Needs Program. The West Virginia public school system also serves as a major referral source. Below is a chart that portrays the number of WV school children identified with orthopedic impairments. Also contained in the Block Grants Needs Assessment are materials depicting clinical activities across the state which are largely focused on orthopedic conditions.

**West Virginia
Number of Students with Orthopedic Impairments
1980-88, 1994-99**



Source: WV Department of Education; Exceptional Students in West Virginia's County School Districts - FY 99

In FY 99, the CSHCN Program served 6,607 children through 13,416 visits to their statewide system of clinics with office visits augmenting clinical care. There are eight specialty clinics administered by CSHCN, with some more widely used than others. These clinics are available at more than 60 sites statewide.

Children are seen more frequently if medically indicated; consequently, children with cystic fibrosis attended CSHCN clinics more often than children with hearing impairments or those needing eye surgery. Since a child/family may not all be equally in need of social service support, the CSHCN have developed a mechanism for determining the level of need. Consequently, a family/child could have high medical need as in the case of a youngster with cerebral palsy or cystic fibrosis, but the same family/child may have moderate or low social supportive needs. The determination of client need is a part of the overall child/family assessment which is developed as part of a multi-disciplinary process, with the child/family as the pivotal element.

Medicaid Managed Care has had limited impact upon the CSHCN program in that the SSI populations have not been enrolled in managed care.

In fiscal year 1999, 89% of active CSHCN participants under age 16 were Medicaid cardholders. Helping families with children access health care financing is an integral part of all MCH program services.

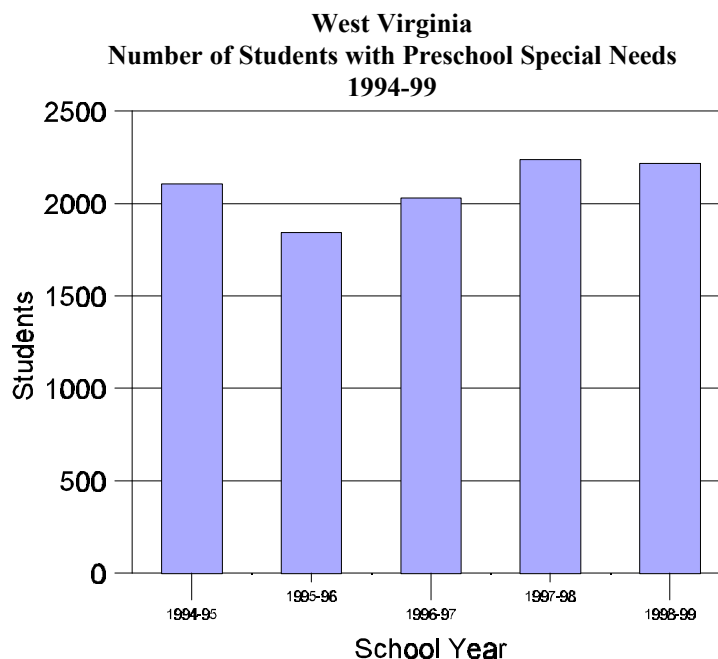
We have negotiated with the administrators of CHIP for enrollment of children who are eligible to participate in CSHCN program services. This plan has been submitted to HCFA, since WV is modifying the original CHIP application/plan to remove Medicaid coverage for CHIP eligibles (Phase I) under age 5 years.

Early Intervention: Birth to Three

The Early Intervention: Birth to Three Program was developed under the Individuals with Disabilities Education Act (IDEA/Part C) to enhance the development of infants and toddlers with disabilities and to minimize their potential for developmental delay; reduce the educational cost to our society, including the nation's schools, by minimizing the need for special education and related services after infants and toddlers with disabilities reach school age, to minimize the likelihood of institutionalization of individuals with disabilities and maximize the potential for their independently living in society; to enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities; and to enhance the capacity of state and local agencies and service providers to identify, evaluate, and meet the needs of historically under-represented populations, particularly minority, low-income, inner-city and rural populations.

The Birth to Three System (Part C/IDEA) housed within MCH is largely financed by Medicaid. In FY 98, Medicaid expenditures for this program was approximately 7 million dollars, while Part C and state allocation paled in comparison at 3.5 million dollars. Part C is administered locally under contract with providers who are mental health (behavioral health) licensed.

The number of children in the system ebbs and flows...at onset, the overall enrollment was 1,700 youngsters per year, to an increasing program growth estimated for FY 99 at 3,800 toddlers.



*Does not include DB schools.

Part C eligibility in West Virginia is as follows:

- Age eligibility includes children up to 36 months.
- There are no financial eligibility requirements.
- Eligibility is based only on a child meeting one of the following definitions.
 - Is experiencing a developmental delay:
An infant or toddler who has been diagnosed by a multidisciplinary team as having a significant delay in one or more of the following areas of development:
 - cognitive development
 - physical development including vision and hearing
 - communication development
 - social and emotional development
 - adaptive development
 - Has a diagnosed physical or mental condition which has a high probability of resulting in developmental delay – includes infants/toddlers who have a diagnosed condition but may not be demonstrating delays at the time of evaluation. Examples of such conditions include, but are not limited to:
 - Down Syndrome and other chromosomal abnormalities associated with delay;
 - Congenital syndromes or genetic disorders associated with developmental delays; and/or inborn errors of metabolism.
 - Is at significant risk of having substantial developmental delays if early intervention (EI) services are not provided. Risk may be established when children are experiencing a combination of multiple biological and/or environmental risk factors in accordance with the state definition.

A variety of specialists may be called upon to help the family decide what strategies and services they need. These specialists may include among others:

- audiologists
- counselors, social workers
- child development specialists
- nurses
- occupational therapists
- physical therapists
- registered dieticians
- speech language pathologists
- vision specialists

Local Birth to Three Programs may provide these services directly or through a variety of other community providers. Services may also include transportation as necessary to receive other Birth to Three services.

The ability to access all the above disciplines is a challenge to local Birth to Three providers. To address this issue, the West Virginia Early Intervention Interagency Coordinating Council and the Office of Maternal and Child Health have identified recruitment and retention of specialty disciplines (physical therapy, speech language pathology and occupational therapy) as a critical part of the state's obligation to provide comprehensive early intervention services to infants and toddlers with developmental delays and their families.

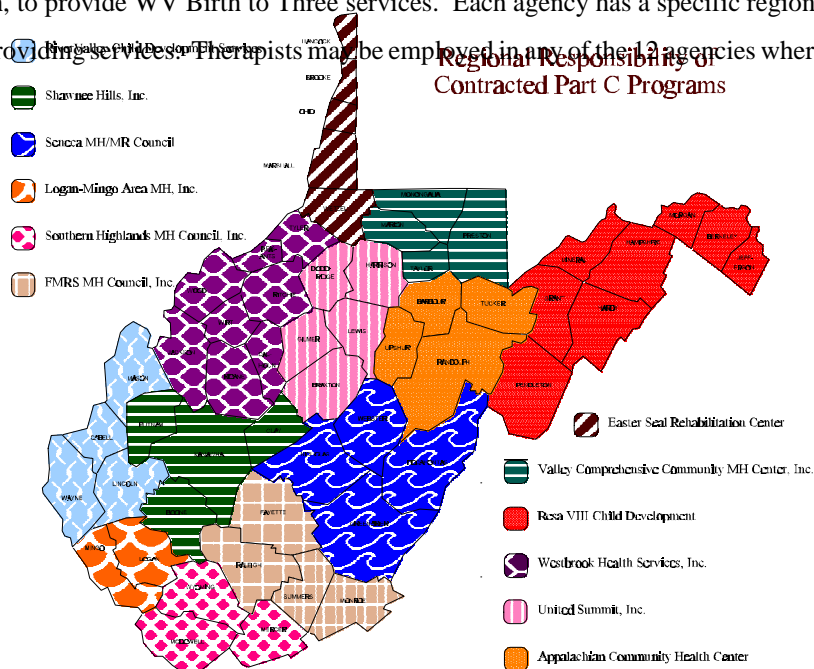
Building Service Capacity

The Recruitment for the Early Intervention Program (REIP) provides financial and other supports – such as training opportunities – to students in therapy programs and licensed therapists who commit to working full-time with one of the Part C Birth to Three sites in West Virginia.

Program Benefits: REIP has funding available for therapy students, new graduates, and already practicing therapists who are interested in early intervention job opportunities. These funds may be used for loan repayment, tuition, continuing education courses, and other activities. To receive REIP funds, the therapist must commit to full-time employment with a Part C WV Birth to Three Program in a priority need area of the state for a predetermined length of time.

Mentorship: The local early intervention program working in conjunction with the state early intervention office will provide supports to link newly practicing therapists with mentor therapists.

Job Opportunities: Twelve agencies contract with the Bureau for Public Health, Office of Maternal and Child Health, to provide WV Birth to Three services. Each agency has a specific region for which it is responsible for providing services. Therapists may be employed in any of the 13 agencies where a need exists.



Collaboration is a fundamental concept in early intervention. A strong link to child care services is important for all children, including those with disabilities, since children and families have many types of need. The West Virginia, Part C, Birth to Three Program has strong relationships with child care and sponsors skill building opportunities for early interventionists, child care providers, and special education teachers in an effort to improve quality and service infrastructure.

The Individuals with Disabilities Education Act (IDEA) requires school districts to “ensure that all children with disabilities within its jurisdiction are identified, located, and evaluated.” Public Law (P.L.) 99-457 emphasizes the need to include parents in the process. Preschool screening programs and public health population surveillance systems serve as sources for identification of children with special needs, including those with developmental delay, see Section 3.1.2.4 for the diagram.

In West Virginia, oversight of Part B IDEA special education services belongs to the State Department of Education, Office of Special Education. In an effort to guarantee a free, appropriate education for all children with disabilities, ages 3 to 21, the Office of Special Education directs an administrative structure for statewide management of special education programs, services, and resources. Moreover, the Office strives to enhance communication between the Department of Education and all agencies, including the Office of Maternal and Child Health, who provide services to exceptional children. With this core principle in mind, the Office of Special Education supports agencies in their efforts to provide services and programs to meet current and future needs of students with exceptionalities and their families. The mission of the Office of Special Education is “To positively affect the lives of children with exceptionalities by developing and enhancing the capacity of stakeholders through positive proactive leadership and collaborative partnerships.”

**Number of West Virginia Students Who Have Preschool Special Needs
Receiving Special Education and Related Services
1997-99**

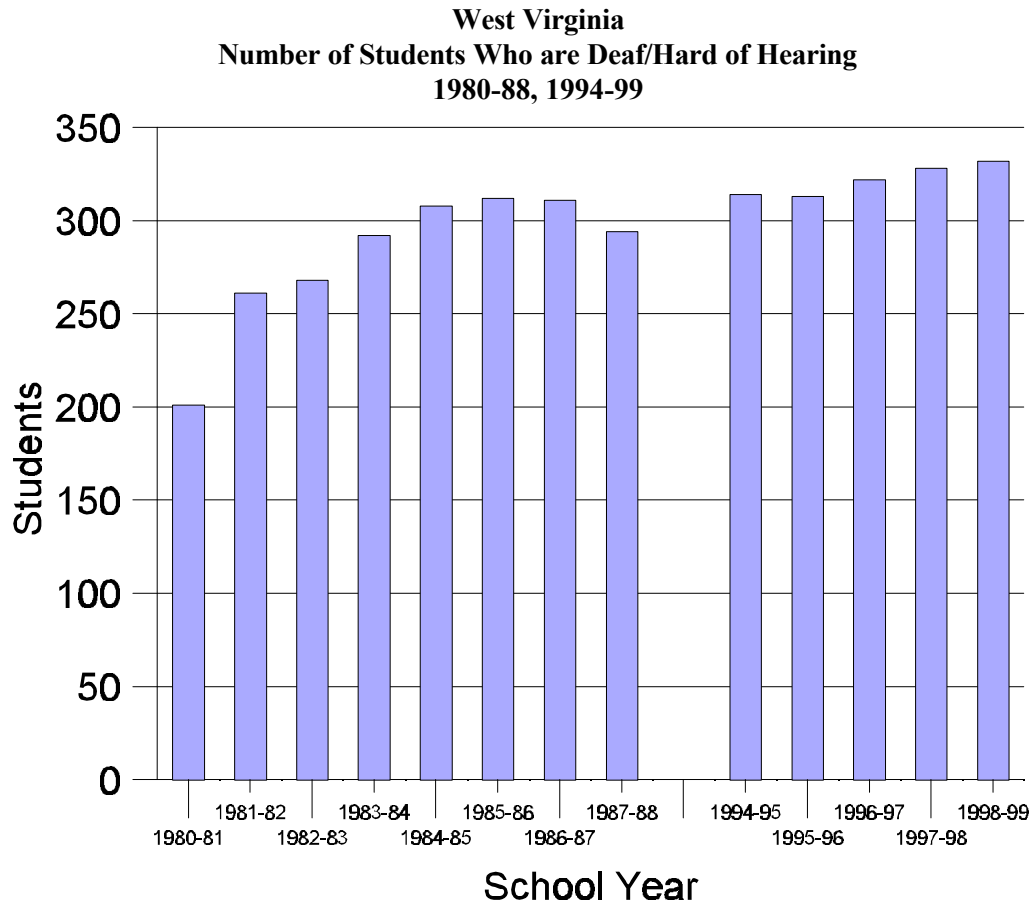
	1997-98		1998-99	
	Count	% of Enrollment	Count	% of Enrollment
Barbour	19	0.65%	10	0.35%
Berkeley	20	0.16%	21	0.17%
Boone	6	0.13%	8	0.17%

	1997-98		1998-99	
	Count	% of Enrollment	Count	% of Enrollment
Braxton	61	2.20%	64	2.31%
Brooke	10	0.25%	8	0.20%
Cabell	115	0.85%	89	0.67%
Calhoun	46	2.95%	48	3.25%
Clay	0	0.00%	0	0.00%
Doddridge	11	0.80%	11	0.83%
Fayette	149	1.83%	134	1.72%
Gilmer	0	0.00%	0	0.00%
Grant	13	0.67%	14	0.71%
Greenbrier	30	0.51%	30	0.51%
Hampshire	28	0.81%	35	1.01%
Hancock	11	0.23%	11	0.23%
Hardy	32	1.53%	45	2.10%
Harrison	67	0.56%	71	0.59%
Jackson	111	2.18%	116	2.29%
Jefferson	18	0.23%	28	0.37%
Kanawha	259	0.82%	228	0.74%
Lewis	54	1.90%	38	1.33%
Lincoln	23	0.54%	22	0.54%
Logan	11	0.16%	11	0.16%
Marion	55	0.62%	64	0.72%
Marshall	25	0.43%	24	0.41%
Mason	75	1.68%	101	2.30%
Mercer	89	0.89%	93	0.94%
Mineral	13	0.27%	10	0.21%
Mingo	15	0.25%	18	0.32%
Monongalia	56	0.54%	79	0.76%

	1997-98		1998-99	
	Count	% of Enrollment	Count	% of Enrollment
Monroe	47	2.27%	36	1.76%
Morgan	9	0.40%	13	0.57%
McDowell	16	0.28%	11	0.20%
Nicholas	22	0.45%	7	0.15%
Ohio	11	0.17%	16	0.26%
Pendleton	20	1.41%	20	1.48%
Pleasants	14	0.95%	16	1.12%
Pocahontas	32	2.13%	32	2.16%
Preston	18	0.29%	20	0.39%
Putnam	38	0.43%	37	0.42%
Raleigh	94	0.74%	84	0.67%
Randolph	13	0.26%	11	0.22%
Ritchie	44	2.38%	47	2.54%
Roane	84	2.84%	88	3.04%
Summers	7	0.39%	5	0.29%
Taylor	14	0.51%	11	0.41%
Tucker	20	1.51%	15	1.17%
Tyler	8	0.48%	6	0.37%
Upshur	10	0.24%	12	0.29%
Wayne	26	0.33%	29	0.37%
Webster	3	0.16%	7	0.38%
Wetzel	19	0.50%	24	0.65%
Wirt	14	1.15%	15	1.26%
Wood	147	1.00%	153	1.06%
Wyoming	92	1.84%	75	1.60%
State	2,239	0.74%	2,219	0.75%

Source: WV Department of Education; Exceptional Students in West Virginia's County School Districts

- FY 99



*Does not include DB schools.

Source: WV Department of Education; Exceptional Students in West Virginia's County School Districts - FY 99

Special Education - Part C Collaboration

As in all states, children in West Virginia are often eligible for services offered by both the Office of Special Education and the Office of Maternal and Child Health. Partnership activities between the two groups have proven beneficial. In recent years, OMCH and the Office of Special Education have collaborated in the highly successful summer "Camp Gizmo." Camp Gizmo uses assistive technology to promote inclusion for young children and their families. Held in July at the School for the Deaf and Blind in Romney, the camp is an interagency partnership, which brings together parents, professionals and their children in an inclusive setting. The camp concentrates on developing teams from communities throughout West Virginia that work on strategies for helping each child attending Camp Gizmo to participate fully both at camp and back in their home communities. Although the camp's focus is recreational, strategies are developed to increase the children's mobility, communication and inclusion. Professional disciplines participating include early

interventionists, occupational therapists, physical therapists, speech language pathologists, social workers, special education teachers, nurses, and parent educators. Children range in age from 1 to 8 years of age and include siblings of children with disabilities and children of professionals who attend the camp.

Other aspects of Camp Gizmo focus solely on camp activities. Professionals, parents and children team up to enjoy baseball, a cookout, a square dance with live West Virginia old time music and calling, a swim party and many other activities. The teams work to make the necessary modifications to facilitate inclusion.

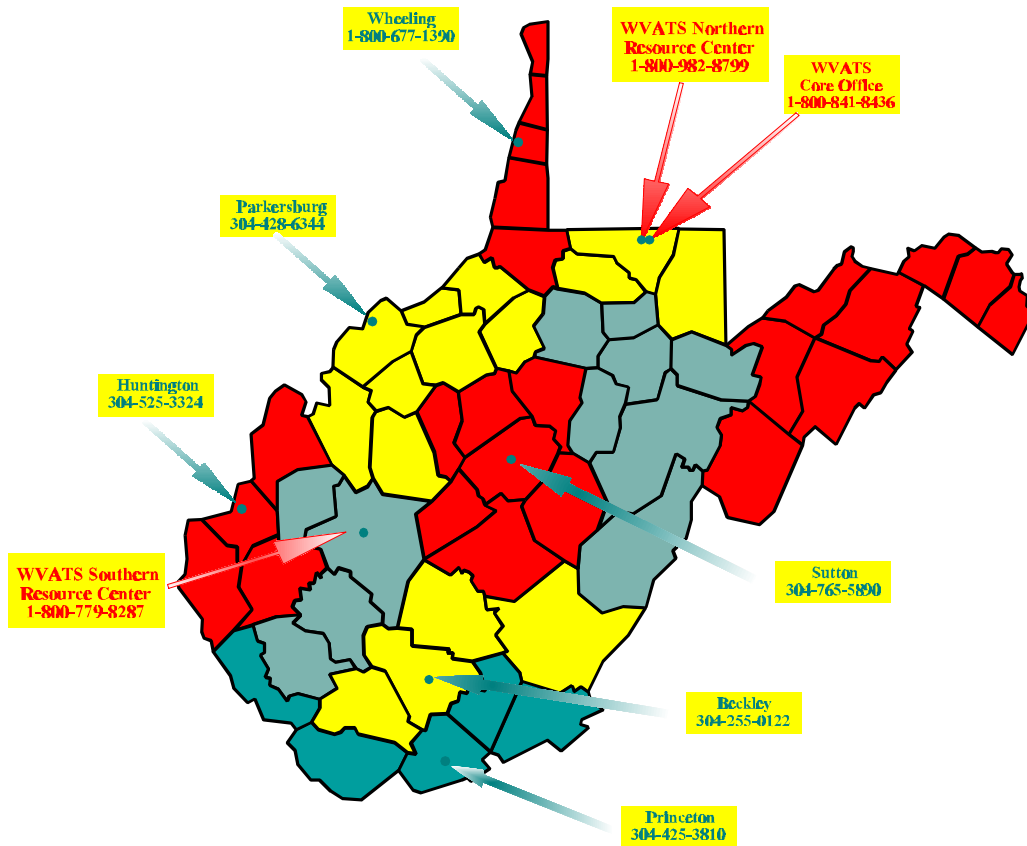
The camp is planned and conducted by the statewide A-Team. The A-Team is a group of parents and service providers with a special interest in assistive technology. The A-team is funded by the West Virginia Early Intervention Program. Camp co-sponsors include the West Virginia Department of Health and Human Resources, Bureau for Public Health, Office of Maternal and Child Health, Birth to Three, and the West Virginia State Department of Education, Office of Special Programs. Other agencies involved in the planning and implementation are the West Virginia Assistive Technology Systems/University Affiliated Center for Developmental Disabilities, West Virginia Division of Rehabilitation Services; Marshall University, and West Virginia University's Klingberg Center for Child Development.

Camp Gizmo fulfills the Tech Act mandates of increasing access to assistive technology, involving consumers in the process, providing training and services to underserved rural families, and changing systems.

Parents of children with disabilities assist in the planning of Camp Gizmo. They act as team leaders and presenters. Teams are invited from WV Birth to Three programs and schools from around the state. Each team consists of professionals and at least one family of a child with disabilities. The children participate in camp activities while their parents attend classes. Several young adults with disabilities assist with camp activities.

The OMCH works on the WV Assistive Technology System (WVATS) to provide information and referral through toll-free hotlines, provide demonstrations to showcase assistive technology devices, and loan assistive technology devices through resource centers, one of which is administered by MCH. WVATS Tech Teams are also available to disseminate information about assistive technology and support the activities of people with disabilities, see the map depicting availability of service.

WVATS Resource Centers and Tech Teams



Use of Assistive Technology Devices and Services for Infants and Toddlers Across the U.S.		
Year	Birth to Three Population Receiving Early Intervention Services	Birth to Three Population Receiving at Device and Services
1992	143,392	5,861
1993	154,065	6,678
1994	165,253	7,352
1995	177,734	9,274

Use of Assistive Technology Devices and Services for Infants and Toddlers Across the U.S.		
Year	Birth to Three Population Receiving Early Intervention Services	Birth to Three Population Receiving at Device and Services
1996	*	*
1997	*	*
1998	*	*
1999	*	*

*Not Available - Contacted RESNA in April, 2000.

Further collaboration is portrayed in the work with the Bureau for Children and Families, Office of Family Support, who asked OMCH to develop a program to assist Welfare recipients' participation in the workforce. The project called "Pre-Employment Services," arranges through the private sector, vision and dental care for persons identified as workforce candidates by the Family Support Specialists.

The project, which started in November, 1999, has recruited 192 dentists and 137 optometrists to care for the population. Provider recruitment efforts continue with MCH having established a Recruitment Unit, which at this point, is solely focused on recruiting practitioners to serve this targeted group. Approximately 6 million dollars of TANF resources have been dedicated to this project.

Details of other public health endeavors involving TANF are discussed in Section 3.1.2.4.

As a part of the Welfare to Work plans, the entire Department of Health and Human Resources has joined together to improve the quality and the availability of care. MCH is a stakeholder for many reasons, not the least of which is our desire to have child care facilities able and willing to accommodate children with special needs.

Child Care in West Virginia

Subsidizing the cost of child care began in West Virginia in 1969 to enable low-income families to enter employment or training. During the next 10 years, from 1969 to 1979, the program grew rapidly from serving 300 children to serving 4,500 children.

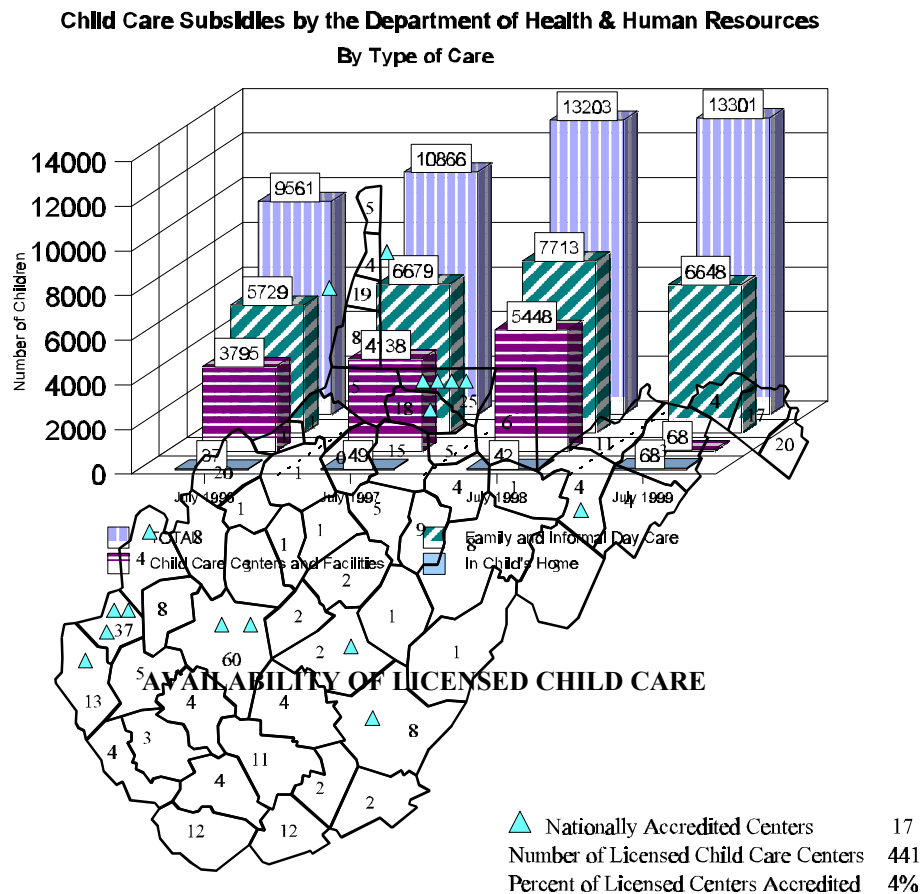
The 1970's were a decade of improvement in child care services in West Virginia. Child care licensing standards were significantly upgraded, and a competency-based training program for all care givers was developed. West Virginia designed a unique approach to training family child care providers by employing and training 150 paraprofessionals as trainers; these trainers delivered the training in the home of the family child care provider. Child care providers received their training from state child care consultants who visited their centers. Incentive payments in three phases during the training, called "enrichment rates,"

were used to encourage and sustain involvement in the training.

In the 1980's, women entered the labor force in rapidly increasing numbers, placing greater demands on the child care system. At the same time, federal funding to meet these needs were reduced. With fewer dollars, the state was forced to reduce staff. New demands for child care increased caseloads and, with no expansion in staffing, the state stopped all training of child care providers.

Caseload Growth

The 1990's are witnessed a period of significant caseload growth in West Virginia. Moreover, the growth in the number of child care centers has been dramatic. In 1997, there were 300 licensed centers, and in 1999, there were 441. The total caseload of children whose care was subsidized in 1996 was 9,561, and now in 1999, it is 13,301. The bar chart below shows this progressive growth in the number of low income children cared for in various child care settings. A map of the licensed child care centers noting those accredited in the National Association for the Education of Young Children (NAEYC) is cited below. Only two years ago, nine counties in the state had no child care centers and many counties had only one center. Now, only one county, Doddridge, has no licensed child care center:



Child Care Investment

On the eve of the twenty-first century, West Virginia's Child Care Program has been enormously enriched with Temporary Assistance for Needy Families (TANF) funds. The state received \$10 million in improvements for 1999, and \$22 million is committed for the year 2000. Improvements included:

- special grants to centers;
- an increase in the eligibility level to 150% FPL
- funding and implementation of six child care resource and referral agencies to provide infrastructure necessary for a quality system;
- increased subsidy rates; and
- the development of a curriculum for training child care providers caring for infants and toddlers. Once this training is developed and outcome measures created, care giver graduates will be paid higher fees. The joint training program is an engagement with MCH/Part C.

The Way We Were

Just two years ago, West Virginia's child care program was dismal at best. It had the lowest income cut off in the nation. This undoubtedly is the reason West Virginia, among all states, served the lowest percentage of its eligible population; in simplest terms, not many children were eligible who otherwise would have been eligible in most other states. In addition, the child care program had a serious monitoring problem since there were few licensing staff and, in fact, many child care programs were not monitored at all. Only eight percent of its elementary schools offered after-school programs. Comprehensive training programs for providers were not available, and the rates paid to programs to care for low-income children were significantly below market rates; therefore, compromising the state's ability to find good care for the families it served.

Furthermore, there were no incentives in the system to improve the program.

How West Virginia's Child Care Program Measures Up

Despite all of the improvement West Virginia has made recently, there are a number of areas where West Virginia's program does not match what we know to be factors associated with quality child care.

The ratio of care givers to infants in West Virginia is 1:4; a quality standard is 1:3. In addition, in West Virginia, one teacher is permitted to care for up to 10 three year olds. The quality standard is 1:7.

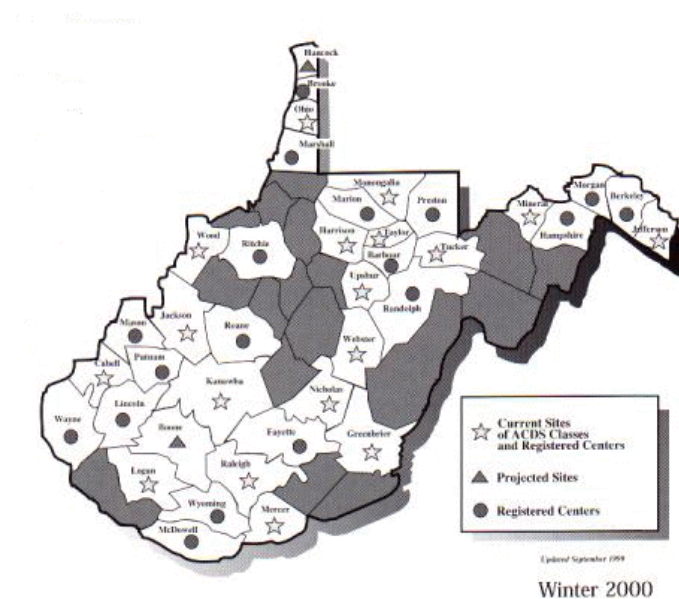
Given the considerable importance of college training and training before providing care, West Virginia's program is woefully inadequate. Its licensing and/or certification standards require no training prior to service, and there is no coordinated program to provide training.

Building Capacity

Ten years ago, 17 apprentices began the first class of the Child Care Apprenticeship Training Program in Cabell County. From that beginning, it has evolved into the Apprenticeship for Child Development Specialist (ACDS) that is now a statewide system and a national model for the professional development of early care and education providers. More than 30 counties in West Virginia are involved in ACDS. More than 750 apprentices have completed the program and have received a nationally recognized certificate from the United States Department of Labor. The ACDS State Executive Council works diligently to ensure continuity of the program as it expands to many counties throughout the state.

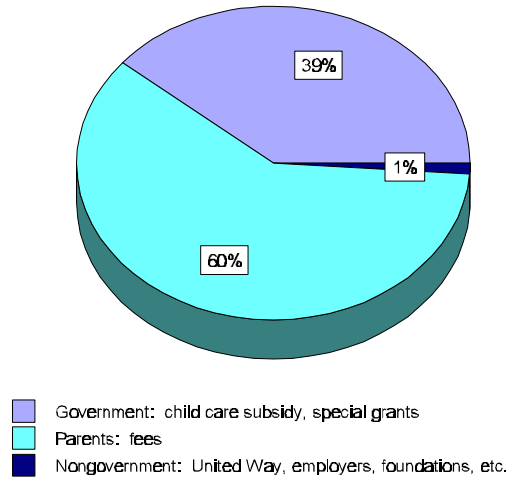
Recently, Governor Cecil Underwood issued a proclamation recognizing ACDS and encouraging all citizens to recognize the importance of quality child care and education.

APPRENTICESHIP FOR CHILD DEVELOPMENT SPECIALIST PROGRAM



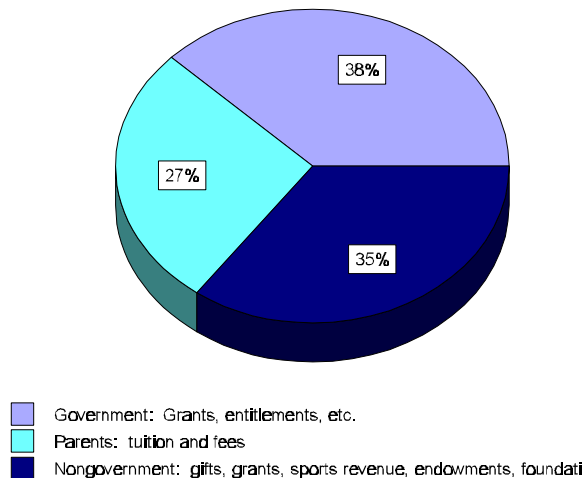
Source: WV Early Childhood Provider Quarterly

Child Care Funding in the U.S.



The availability of a trained workforce to care for West Virginia's children, including those with disabilities, is a recognized need throughout the state. Policy and system changes precipitated by Welfare Reform have only served to accelerate the level of attention given child care initiatives. The Office of Maternal and Child Health, Governor's Cabinet on Children and Families, Office of Social Services, and the West Virginia Department of Education have joined together to maximize fiscal resources directed toward training/skill building in this area. See the Early Childhood Training Calendar for FY 2000, Appendix O.

Higher Education Funding in the U.S



Source: Louise Stoney, Presentation at the National Association of Child Advocates Budget Conference, San Diego, CA 1998.

Child Care Need of Low Income Families

There are 118,000 children under age 13 with working parents in West Virginia. Almost half (44 percent or 51,920) of these children live in low-income families with working parents. This percentage will likely increase as welfare reform is fully implemented. Providing affordable, high-quality child care and after-school programs where they are needed in areas with the highest concentrations of low-income families helps parents and also contributes to building stronger neighborhoods. Providing quality child care is well within the capacity of many people if they are taught early childhood development principles.

By investing in the development and expansion of child care and the training of neighborhood residents, jobs can be created for those in the community and dollars are kept there in the community. There are some family child care programs like this in West Virginia, and many more could be developed with the help and support of such groups as the Family Resource Networks and the Child Care Resource and Referral agencies.

**CHILD CARE RATES PAID & CAPACITY -vs- NEED
PER DAY CHILD CARE SUBSIDY
BY TYPE OF PROVIDER**

Provider Type	Basic Rate	Under 2 and/or Special Needs	Accreditation
In-Home and Informal	\$11	\$13	
Family Care	\$11	\$13	\$15
Family Facility	\$14.50	\$15.50	\$15-\$17
Child Care Center	\$17	\$20	\$18-\$22

Source: Office of Social Services, WVDHHR, December 1999

WEST VIRGINIA'S 1999 CHILD CARE CAPACITY AND NEED

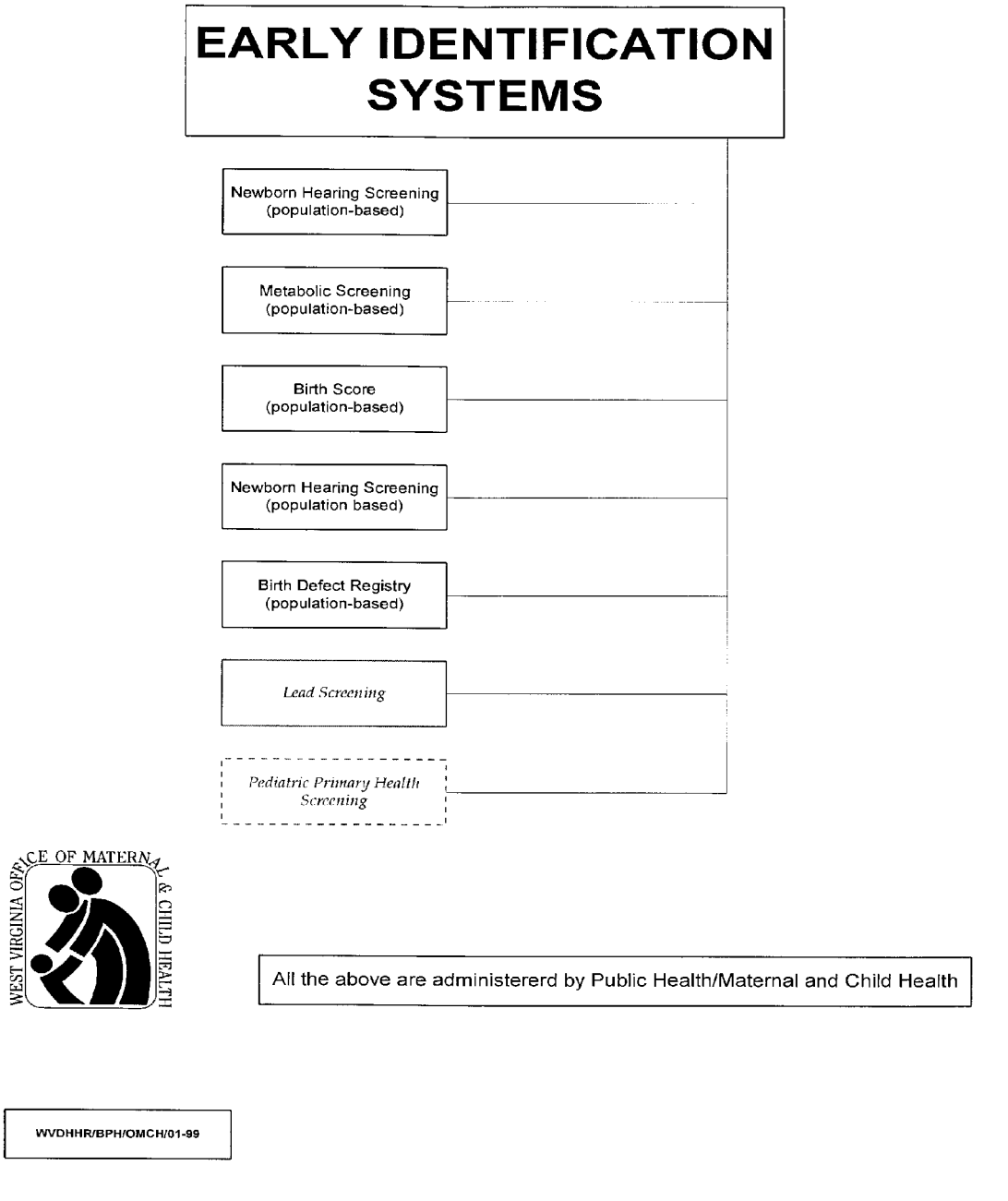
CAPACITY*		NEED	
Number of Licensed Child Care Centers	441	Number of Children Under Age Six with Working Parents (1995)	57,000
Capacity	19,174		
Number of Registered Family Day Care Homes	7,885	Number of Children Ages six to 13 with Working Parents (1995)	61,000
Capacity	23,655		
School Day Plus Sites	184	TOTAL CHILDREN WITH WORKING PARENTS	118,000
Capacity	4,760		
TOTAL CAPACITY	47,589		
*Four hours a day or less care programs, such as nursery schools and private child care arrangements are not included.			

Subtracting the Capacity of Licensed and/or Registered Care Facilities (47,589) from the Number of Children Under 13 with Working Parents (118,000) creates **a need of 70,411 more licensed and regulated slots.**

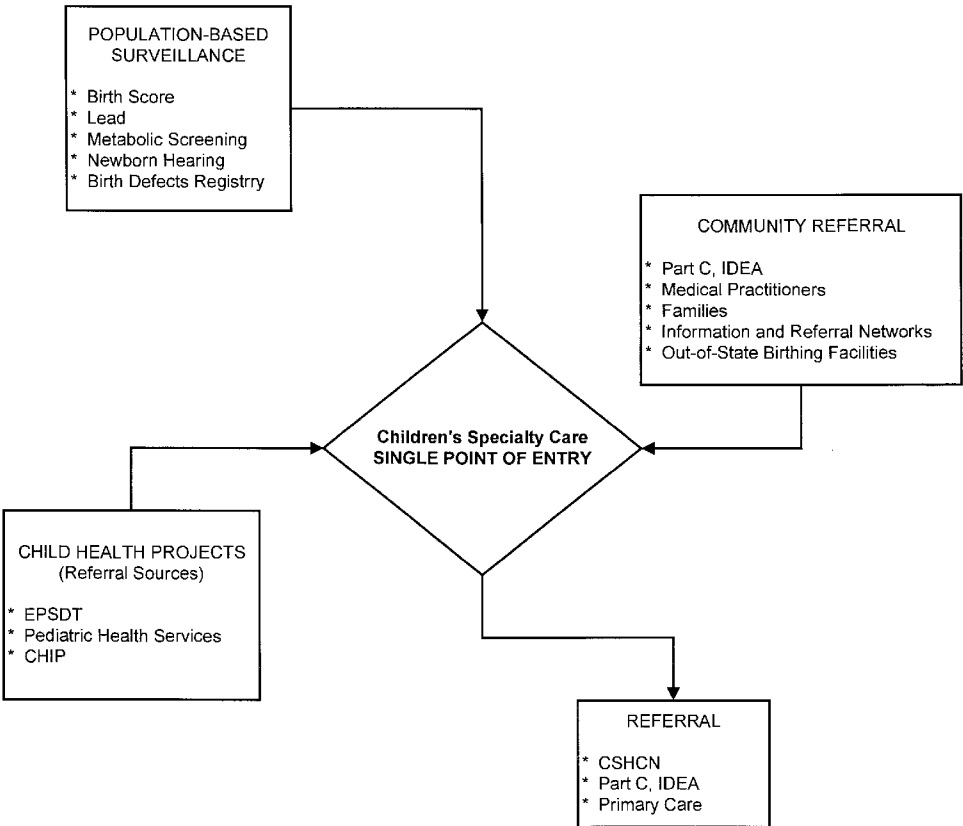
Source: WV Department of Health and Human Resources, Office of Social Sources; WV Department of Health and Human Resources Child Care Licensing; and the 1998 Kids Count Data Book, the Anne E. Casey Foundation, Baltimore, MD.

3.1.2.4 POPULATION-BASED SERVICES

Population-based services in West Virginia are at the heart of what we do for children and families. Multiple population-based screening methodologies serve to identify high risk or at risk infants at birth. The early identification and intervention for this population is designed to ameliorate or lessen the extent of disability by referring the child/family to CSC (CSHCN/Part C-IDEA/Single Point of Entry) and other appropriate services.



EARLY IDENTIFICATION SYSTEMS



WVDHHR/BPH/OMCH/SSDI/12-99

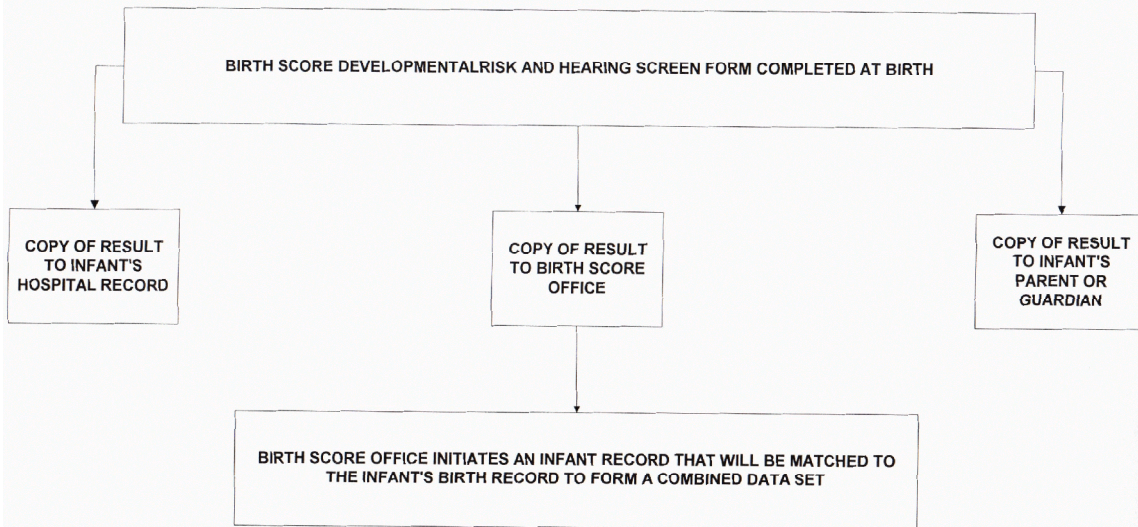


Throughout childhood, access to regular health care is essential to prevent disease and promote health, as well as to treat acute and chronic conditions. The American Academy of Pediatrics recommends a schedule of six well child visits during infancy to provide adequate immunization against childhood diseases, conduct routine assessment, and provide counseling to parents. The State of West Virginia follows this directive for all its children except infants identified by the birth score (at time of delivery) as being at risk of developmental delay or post-neonatal mortality. For infants identified as high risk at birth, this targeted population receives six child health visits in the first six months of life. This screening, early identification process established in state statute, is called **Birth Score**. The project is administered by the West Virginia University Department of Pediatrics, supported by Title V resources.

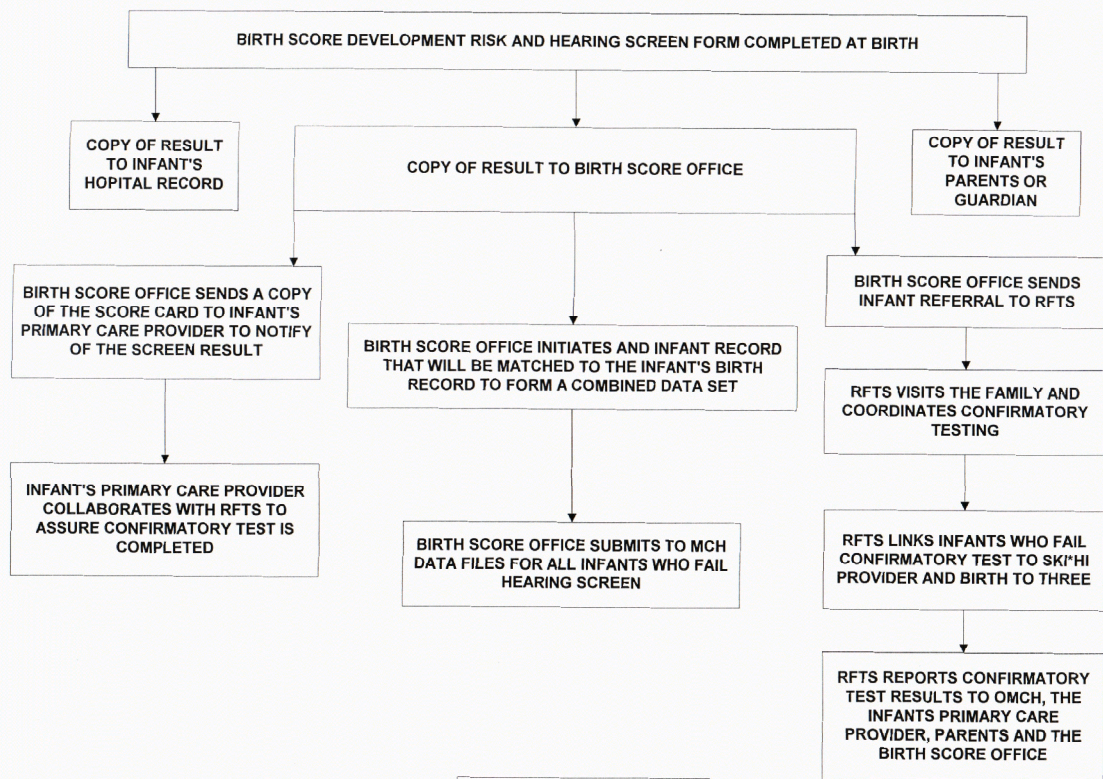
The newest population-based screening methodology for child population is that developed for detection of hearing loss. State legislation does not require screening for hearing loss until July 1, 2000; however, 35% of the state's newborns were screened in FY 99. The OMCH houses this project and has developed tracking, intervention, and follow-up methodologies, see the following diagrams.



INFORMATION FLOW FOLLOWING INFANT HEARING SCREENING WITH "PASS" RESULT



INFORMATION FLOW FOLLOWING INFANT HEARING SCREEN WITH "FAIL" OR "NOT SCREENED" RESULT



WVDHHR/BPH/OMCH/WS/RFTS/3-00

To ensure system capacity, MCH has developed a resource directory distributed statewide which contains information on the availability of ear, nose and throat, audiology, and home visiting services for infants who require diagnostic testing for detection of hearing loss.

While MCH has, since the mid 1990's, administered the **birth registry** (defect), it has only been in recent years that we've used information obtained to reach out to families, encouraging their engagement with the health care system. An example of the data gathering process is depicted below.

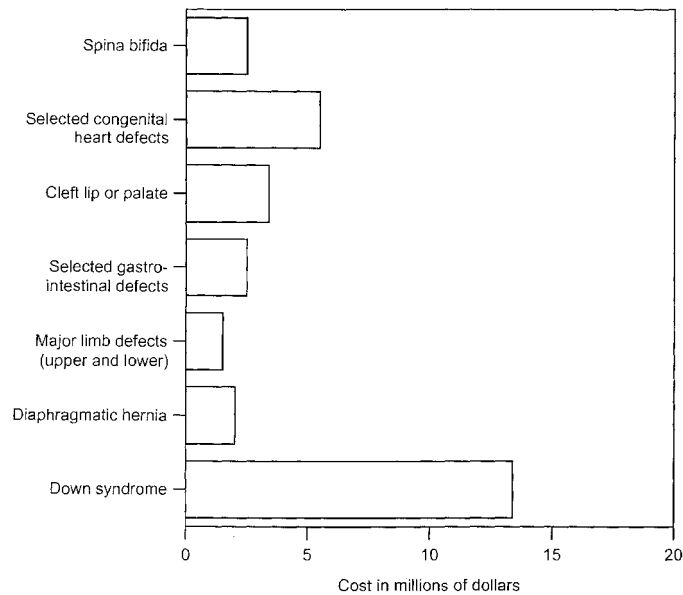
West Virginia Resident Birth Defects Data*
Quarterly Counts of Pregnancies
Affected by Spina Bifida and Anencephaly

Birth Defect	1997					1998					1999				
	1 st	2 nd	3 rd	4 th	Total	1 st	2 nd	3 rd	4 th	Total	1 st	2 nd	3 rd	4 th	Total
Spina Bifida	1	0	2	2	5	2	1	1	1	5	0	1	2	1	4
Anencephaly	2	0	1	8	11	0	1	0	0	1	3	3	2	3	11
Births Covered	5093	5123	5366	5153	20735	5047	5136	5518	5028	20729	4490	4680	5021	4713	18904

*Data as of June 13, 2000

NOTE The datasets from the West Virginia Birth Defects Surveillance System are dynamic and will change as more cases are discovered by physicians.

**Birth Defects: Estimated Lifetime Costs
for Children Born in West Virginia**



Note: The selected congenital heart defects category includes only the three heart defects for which cost data are available: truncus arteriosus, transposition of great vessels, and tetralogy of Fallot. The Selected gastrointestinal defects category includes only esophageal atresia/tracheo-esophageal fistula, colon or rectal atresia, and gastroschisis.

Source: Division of Birth Defects, Child Development, and Disability and Health (proposed), National Center for Environmental Health, CDC

Sudden Infant Death Syndrome

Sudden Infant Death Syndrome (SIDS) is the sudden and unexplained death of an infant under one year of age. SIDS is the major cause of death in babies from one month to one year of age. The death is sudden and unpredictable, and in most cases, the baby seems healthy. Death occurs quickly and usually during a sleep period.

During the calendar year of 1998, January through December, there were thirty-five (35) deaths attributed to Sudden Infant Death Syndrome (SIDs) in West Virginia. The following tables offer summaries of the demographics of those deaths occurring in 1998. Demographics include month of death, county of residence, age at death, sex of child, and distribution of death by race.

While no specific causes for Sudden Infant Death Syndrome have been identified, research has determined that placing infants on their backs can significantly decrease the risk of SIDS. The Office of Maternal and Child Health, Division of Research, Evaluation and Planning's Children's Reportable Disease Project has been an ongoing participant in the national *Back to Sleep* campaign and is making every effort to provide relevant educational material to health care providers as well as parents, grandparents and care givers of West Virginia's newborns.

We also sponsored, in conjunction with the newly chartered West Virginia Chapter of the National SIDS Alliance, the Annual SIDS Walk-a-Thon, in Charleston's Coonskin Park in October of 1998. During SIDS awareness month, we provide infant blankets and packets of education grief information to all West Virginia hospital emergency rooms. These packets of information are to be given to parents in the event of a sudden infant death. We are also sending informational packets on the *Back to Sleep* campaign to all newborn nurseries to be shared with new parents and providing support to train peer counselors. Quarterly SIDS Advisory Committee meetings are convened to discuss program activities.

Number of SIDS Deaths by Month January - December 1998 West Virginia		
Month	Number of SIDS Deaths	Percentage
January	2	5.7
February	2	5.7
March	2	5.7
April	3	8.6
May	6	17.1
June	3	8.6

Number of SIDS Deaths by Month January - December 1998 West Virginia		
Month	Number of SIDS Deaths	Percentage
July	2	5.7
August	1	2.9
September	2	5.7
October	3	8.6
November	5	14.3
December	4	11.4
TOTAL	35	100.0

Number of SIDS Deaths by County January - December 1998 West Virginia		
County of Residence	Number of Deaths	Percentage
Boone	1	2.9
Cabell	3	8.6
Clay	2	5.7
Fayette	1	2.9
Harrison	3	8.6
Jefferson	1	2.9
Kanawha	2	5.7
Logan	5	14.3
Marshall	1	2.9
Mason	1	2.9
Mercer	1	2.9
Mineral	1	2.9
Mingo	1	2.9
Monongalia	1	2.9
Nicholas	1	2.9

Number of SIDS Deaths by County January - December 1998 West Virginia		
County of Residence	Number of Deaths	Percentage
Ohio	1	2.9
Pocahontas	1	2.9
Randolph	2	5.7
Ritchie	1	2.9
Upshur	1	2.9
Wayne	2	5.7
Wetzel	1	2.9
Wood	1	2.9
TOTAL	35	100.0

Number of SIDS Deaths by Age January - December 1998 West Virginia		
Age	Number of Deaths	Percentage
< 1 month	6	17.1
1 - 2 months	8	22.9
2 - 4 months	12	34.3
4 - 6 months	7	20.0
6 - 8 months	1	2.9
8 - 10 months	1	2.9
10 - 12 months	0	0
TOTAL	35	100.0

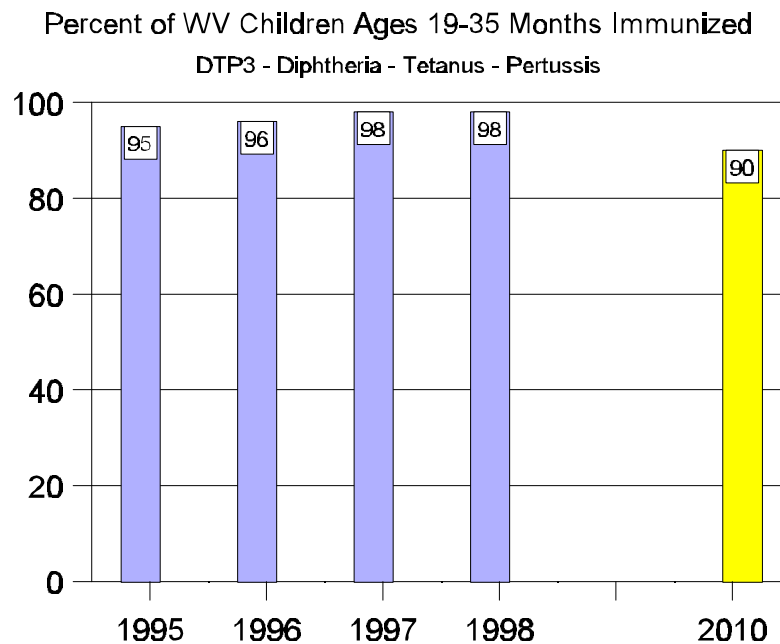
Number of SIDS Deaths by Sex January - December 1998 West Virginia		
Sex	Number of Deaths	Percentage
Male	20	42.9

Number of SIDS Deaths by Sex January - December 1998 West Virginia		
Sex	Number of Deaths	Percentage
Female	15	57.1
TOTAL	35	100.0

Number of SIDS Deaths by Race January - December 1998 West Virginia		
Race	Number of Deaths	Percentage
African-American	1	2.9
Caucasian	34	97.1
Other	0	0
Total	35	100.0

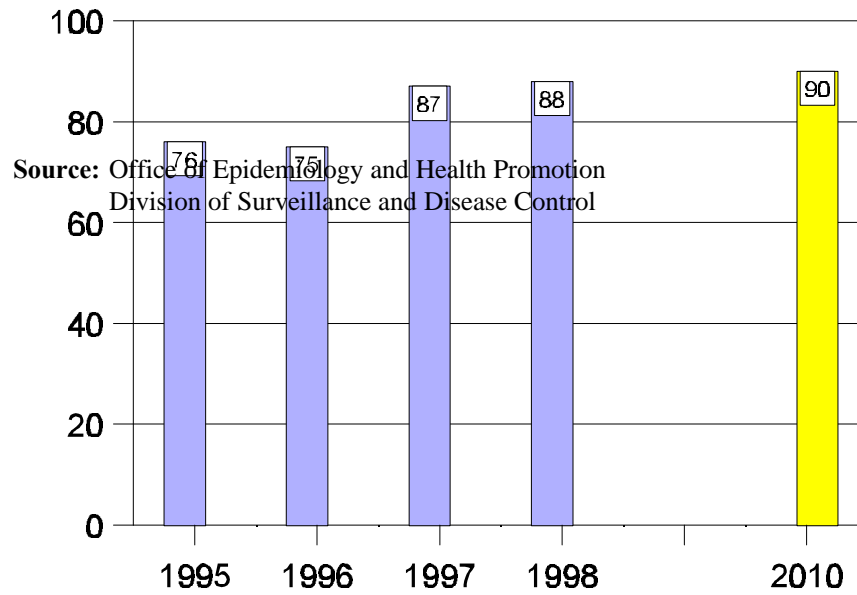
Immunizations

Young children need regular physician visits for many reasons, but one of the most important is to be immunized against preventable diseases. Because all states require up-to-date immunization for school entry, the majority of school-aged children are fully vaccinated. Immunization rates for pre-school children have gradually increased in the state.



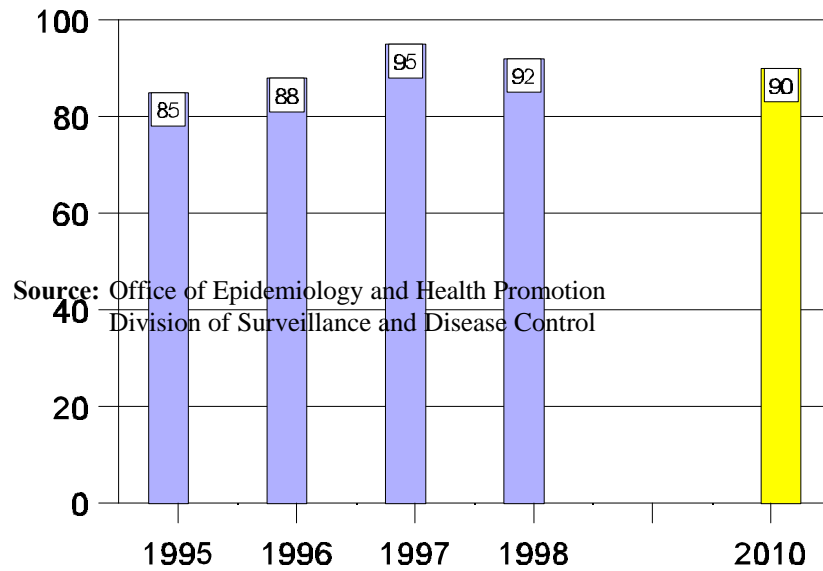
Percent of WV Children Ages 19-35 Months Immunized

DTP4 - Diphtheria - Tetanus - Pertussis

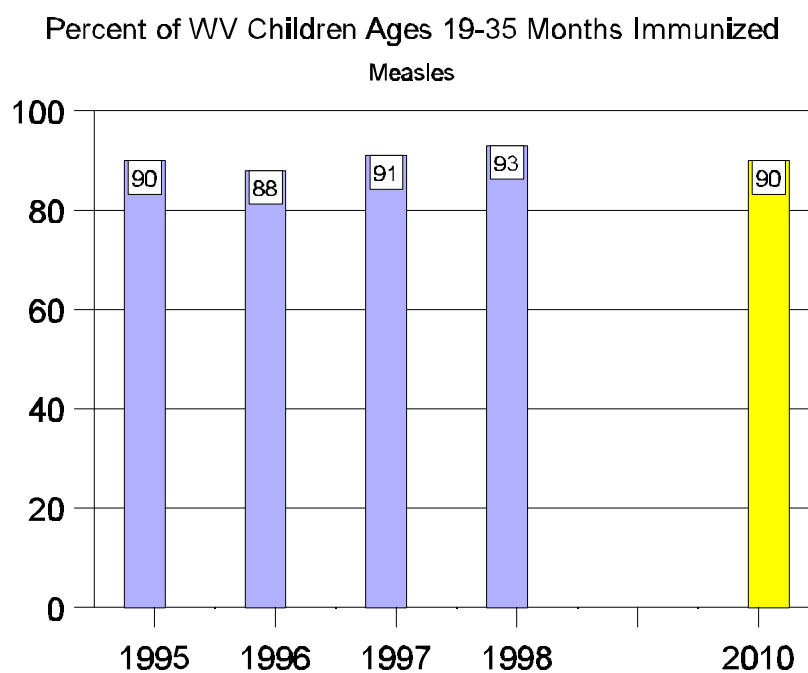


Percent of WV Children Ages 19-35 Months Immunized

Polio



Source: Office of Epidemiology and Health Promotion
Division of Surveillance and Disease Control



Source: Office of Epidemiology and Health Promotion
Division of Surveillance and Disease Control

Oral Health

Dental problems are a sentinel indicator of inadequate access to care. Dental problems are largely preventable through routine, periodic dental care; tooth loss (other than due to injury) or untreated caries are a saga of unmet need within the population.

Clinical guidelines indicate that oral health counseling and dental check-ups should be performed

regularly. Advances in oral health promotion – such as community water supply fluoridation, fluoride toothpaste and sealants, and dental flossing – have significantly reduced the incidence of dental caries. Nevertheless, regular dental care is required to detect and treat problems promptly.

The first visit should occur during early childhood to educate parents and children about oral health and provide treatment if necessary. Non-poor preschool children are more likely to see a dentist than those who are living at or below 150% FPL.

While the likelihood of a dental visit increases once a child enters school, income and lack of financing remain a barrier in West Virginia.

Health Facts About West Virginia's Children's Dental Status

- 62% of West Virginia children between the ages of 8 and 18 have decay in both primary and permanent dentitions.
- Although 54% of children, grades 1-3 are decay free...46% have had cavities by the age of 8.
- While 53% of children in grades 3-12 are decay free...47% have had cavities and/or fillings.
- 36% of West Virginia children have sealants, one of the most effective means of preventing tooth decay but...64% of children do not have sealants and 53% of these need sealants to protect their permanent molars.
- Approximately 214,000 West Virginia children have Medicaid/CHIP coverage, but only 53,500 or 25% of the children actually used it to access dental health services. The availability of dentists, while not prolific, is sufficient to provide more services than are being sought. It is for this reason, WV wishes to focus on oral health education as a means of improving utilization.

ACCESS TO AND AVAILABILITY OF CHILDREN'S DENTAL HEALTH SERVICES					
County	# Licensed Dentists by County	# General Dentists Billing Medicaid**	# Oral Health Specialists Billing Medicaid**	# General Dentists Accepting New Medicaid Patients	# Oral Health Specialists Accepting New Medicaid Patients
	1	2	3	4	5
Barbour	4	4	0	3	
Berkeley	34	12	0	1	
Boone	7	6	0	3	
Braxton	4	4	0	3	
Brooke	6	3	2 Oral Surgeons	1	
Calhoun	2	2	0		
Cabell	53	30	1 Pedodontist 4 Oral Surgeons 1 Orthodontist	20	1 Orthodontist 1 Oral Surgeon 1 Pedodontist
Clay	1	1	0	1	

ACCESS TO AND AVAILABILITY OF CHILDREN'S DENTAL HEALTH SERVICES					
County	# Licensed Dentists by County	# General Dentists Billing Medicaid**	# Oral Health Specialists Billing Medicaid**	# General Dentists Accepting New Medicaid Patients	# Oral Health Specialists Accepting New Medicaid Patients
	1	2	3	4	5
Doddridge	0	0	0		
Fayette	16	15	0	3	
Gilmer	1	1		1	
Grant	5	5	0	4	
Greenbrier	17	15	1 Orthodontist	6	
Hampshire	5	5	0		
Hancock	19	11	0		
Hardy	5	3	0		
Harrison	39	19	2 Pedodontists 2 Oral Surgeons 1 Orthodontist	16	1 Pedodontist
Jackson	10	10	0	1	
Jefferson	11	3	0	2	1 Oral Surgeon
Kanawha	142	87	1 Endodontist 1 Oral Surgeon 4 Orthodontist 3 Pedodontists	36	2 Orthodontists 2 Oral Surgeons
Lewis	4	3	0	3	
Lincoln	5	5	0	3	
Logan	6	6	0	7	
Marion	24	18	2 Oral Surgeons 2 Orthodontists	10	
Marshall	9	9	1 Oral Surgeon	2	
Mason	7	3	0	2	
McDowell	5	4	0	3	
Mercer	29	15	1 Oral Surgeon	4	
Mineral	7	4	0	2	
Mingo	3	3	0	1	
Monongalia	101	53	11 Oral Surgeons 2 Orthodontists 1 Pedodontist 1 Endodontist 3 Periodontists	13	1 Orthodontist
Monroe	1	1	0	1	
Morgan	3	2	0		

ACCESS TO AND AVAILABILITY OF CHILDREN'S DENTAL HEALTH SERVICES					
County	# Licensed Dentists by County	# General Dentists Billing Medicaid**	# Oral Health Specialists Billing Medicaid**	# General Dentists Accepting New Medicaid Patients	# Oral Health Specialists Accepting New Medicaid Patients
	1	2	3	4	5
Nicholas	6	5	1 Oral Surgeon	3	
Ohio	39	17	1 Orthodontist 1 Endodontist 3 Oral Surgeons	7	
Pocahontas	3	3	0	2	
Pendleton	6	5	0		
Pleasants	4	2	0	1	
Preston	6	6	0	5	
Putnam	17	10	1 Orthodontist 1 Pedodontist	4	
Raleigh	39	18	2 Oral Surgeons 2 Orthodontists	4	2 Orthodontists 1 Oral Surgeon
Randolph	14	12	1 Oral Surgeon	9	
Ritchie	2	2	1 Orthodontist	1	
Roane	3	2	0		
Summers	3	1	0	1	
Taylor	3	1	0		
Tucker	4	2	0	1	
Tyler	1	0	0		
Upshur	6	6	0	4	
Wayne	10	8	0	8	
Webster	2	2	0	1	
Wetzel	8	7	1 Orthodontist	4	1 Orthodontist
Wirt	1	1	0	1	
Wood	42	12	1 Orthodontist 2 Oral Surgeons 1 Pedodontist	4	
Wyoming	6	4	0	3	
Out-of-State Providers		25	0	9	
TOTALS	812	526	76	224	14

*All of the out-of-state claims were provided in the State of Maryland.

**Medicaid children includes both Medicaid and CHIP eligible children.

Footnote: #3 includes general dentists who have established Medicaid patients but are no longer accepting new Medicaid patients.

Column 1: WV Board of Dental Examiners, 3/2000

Column 2: WV Department of Health and Human Resources, Medicaid Dental Providers (with old and new provider numbers) by specialty code, 1/24/2000

Column 3: WV Department of Health and Human Resources, dated 3/7/2000

Column 4: Office of Maternal and Child Health mail survey dated 5/16/2000

Column 5: Office of Maternal and Child Health mail survey dated 5/16/2000

Women's Health - Family Planning

The Office also administers population-based services that are for women, to include breast and cervical cancer screening and family planning. Family planning services provide persons of childbearing age with the opportunity to receive medical advice and controlling if and when they wish to become parents. Healthy People 2010 has identified objectives in this area to reduce pregnancies among teenagers younger than 18; and to reduce the number of unintended pregnancies among all women. The social and economic costs associated with teen pregnancies have been well documented, but there may be added health care costs as well. Babies born to teenage mothers, for example, are more likely to be born with low birth weights and to die in infancy compared to infants born to mothers in their twenties.

Women's access to family planning appears to be an important general determinant of prenatal outcomes. To the extent that effective family planning widens the intervals between births and ensure that pregnancies are intended, babies may be born healthier.

In line with many other Title X grantees across the country, the Family Planning Program has experienced a decrease in the number of clients receiving clinical services over the past four years. Trends in service data were evaluated for the past eight years, to consider variables that may have impacted or contributed to declining enrollment, and to consider various strategies for increasing Family Planning Program enrollment.

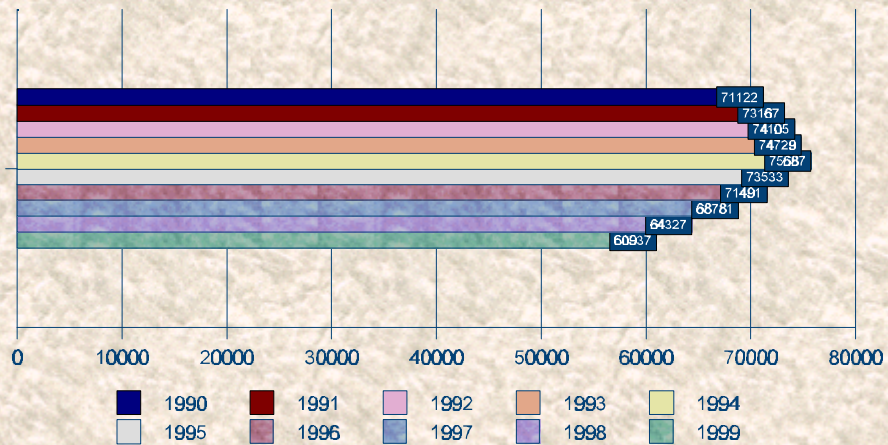
Further, in 1995, the Family Planning Program experienced a decline in client enrollment, a situation which had not occurred since the early 1980's. From 1995-1998, clinical service data indicated a 15% decrease in the number of clients receiving services. A situation analysis indicated the following possible factors contributed to declining Family Planning Program enrollment:

- Improved Family Planning Program eligibility policies, with modifications to data management system
- Shift of clients to private sector
- Initiation of Breast and Cervical Cancer Screening Program (1992-1993); Family Planning Program previously served as Pap screening program for numerous individuals not primarily seeking contraceptive services; i.e., older age, post-sterilization, etc.
- Medicaid Managed Care (implemented 1996).

Refer to the following data charts detailing client utilization data.

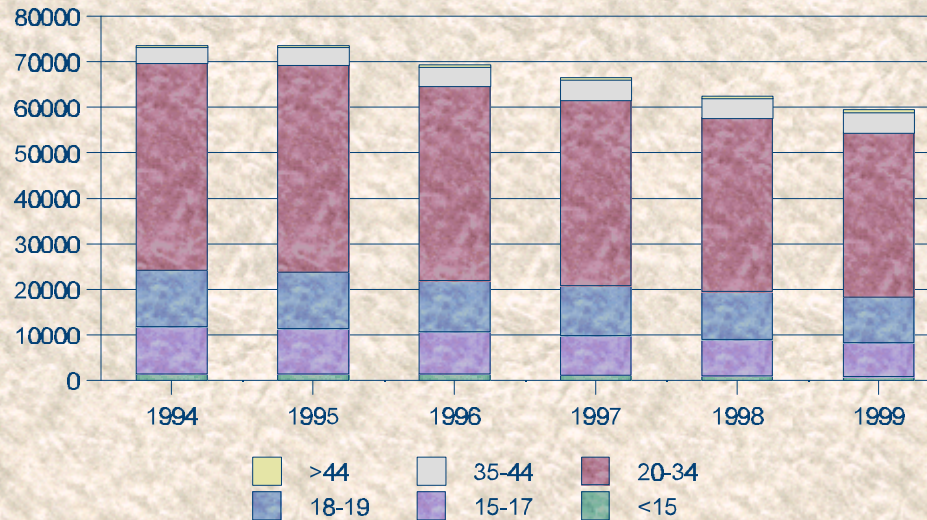
FAMILY PLANNING PROGRAM

PATIENTS SERVED (UNDUPLICATED)
1990 - 1999



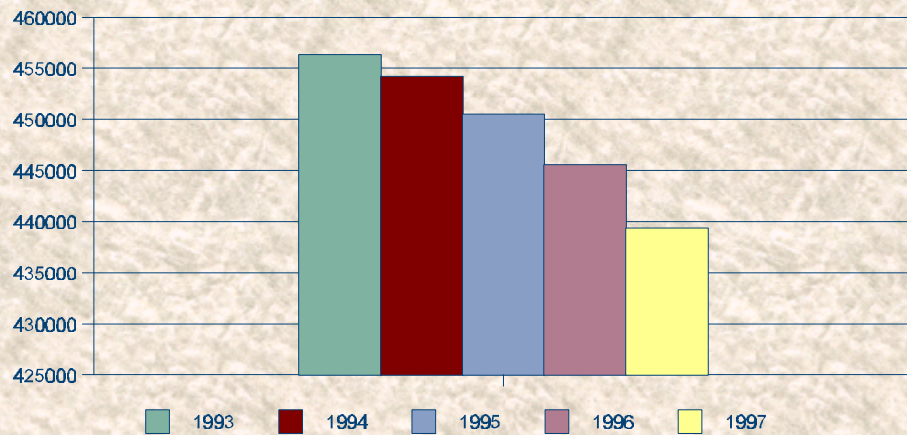
FEMALE CLIENTS, BY AGE (UNDUPLICATED)

1994 - 1999



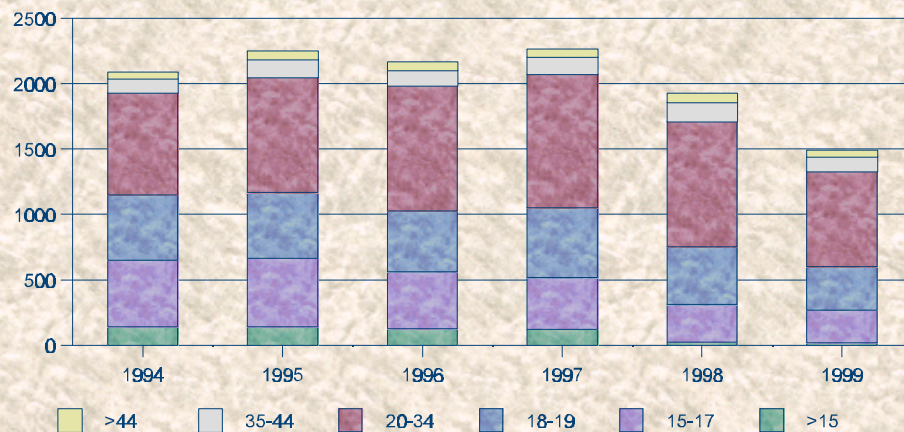
WV POPULATION FEMALES, AGES 12 - 45

1993 - 1998



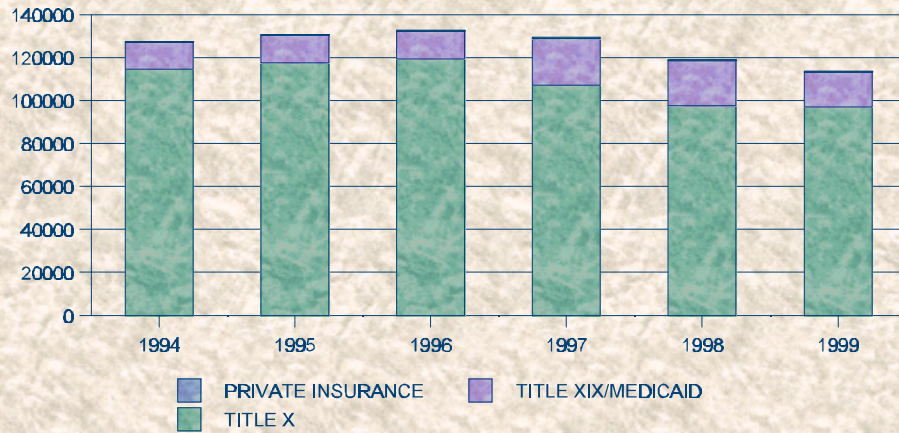
MALE CLIENTS, BY AGE (UNDUPLICATED)

1994 - 1999



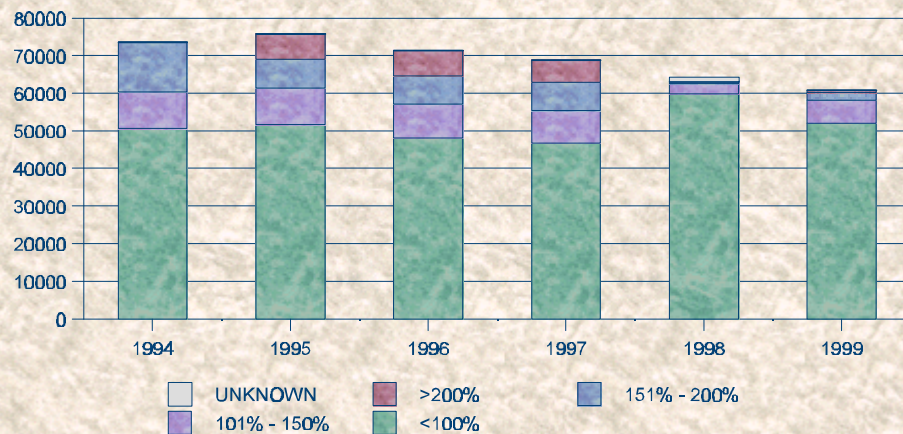
PAYOR SOURCE

NUMBER OF VISITS, 1994 - 1999

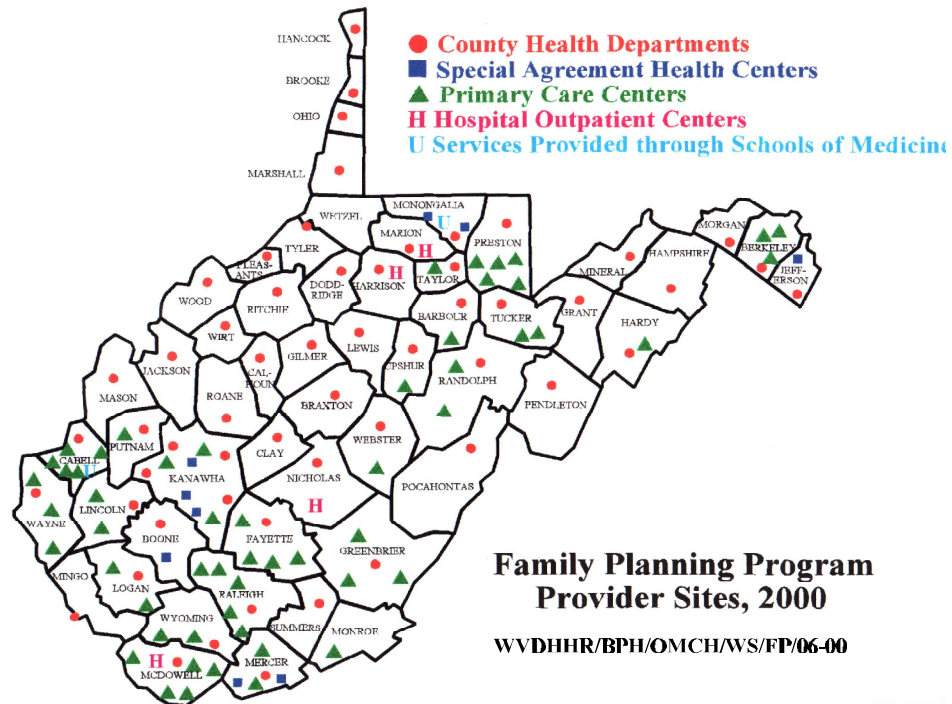


CLIENT INCOME STATUS

FEMALES AND MALES, 1994 - 1999



Improving the availability of contraceptive care for persons of childbearing years has been a conscious strategy in WV to reduce the incidence of low birth weight, to reduce infant mortality, and improve the general health of perinatal populations. There are currently 128 family planning sites throughout WV.



In response to declining participant numbers in family planning, and increased emphasis on work readiness, MCH has used TANF resources to increase public and professional awareness about family planning services. This included media messages targeted toward adolescents, as well as presentation to Department of Health and Human Resources staff, called Family Support Specialists, responsible for case planning of persons moving from Welfare to work. Educational workshops were provided at 12 sites with 208 Family Support Specialists in attendance. Three additional workshops are scheduled in August 2000, see map for training site locations.

[illegible]

Map of West Virginia showing county boundaries and the locations of 30 radio stations. The stations are labeled with their call letters and frequencies, often followed by their city of origin.

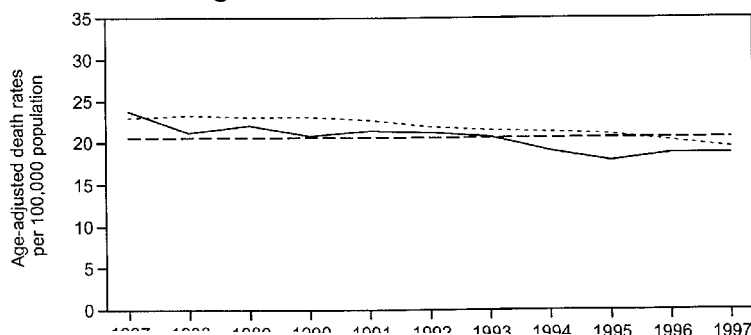
- Wierion WERI-AM
- Wheeling WOMP-FM WOMP
- New Martinsville WETZ
- Morgantown WVAQ-FM WAJR
- Fairmont WRLF-FM WYCS WMMN
- Kingwood WFSH-FM WFSP
- Berkeley WDHC-FM WCST
- Martinsburg WKMZ-FM WEPM
- Charles Town WMRE
- Keyser WQZK-FM WKLP
- Fisher WELD-FM WELD
- Elkins WDNE-FM WDNE
- Sutton WCKA-FM WSGE
- Summersville WCWV-FM
- Richwood WVAR
- Rupert WYKM
- Renovate WRON-FM WRON
- Beckley WTNJ-FM
- Mullens WPMW-FM
- Blacksburg WBAJ-FM WHIS
- Tazewell WTZE
- Welch WELC-FM WELC
- Marion WZAC-FM
- Cogan WQOW-FM WVOV
- Williamson WXCC-FM WBTN
- Matineer WHJC-FM
- Charleston WCHS WCAW WSWW WRVZ-FM
- Spencer WVRC-FM WVRC
- Ripley WCEF-FM
- Huntington WDGJ-FM WBVG
- Parkersburg WNUS-FM WLTP
- Claarksburg WISSN-FM WWHF-FM WHAR
- Grafton WYBZ-FM WTBZ

- Media Campaign (radio coverage portrayed above)
- Distribution of brochures
 - public schools
 - public officials (mayors, county commissioners, etc.)
 - faith leaders
- “Mother’s Day Too Soon” print ad campaign was circulated statewide in all local newspapers.

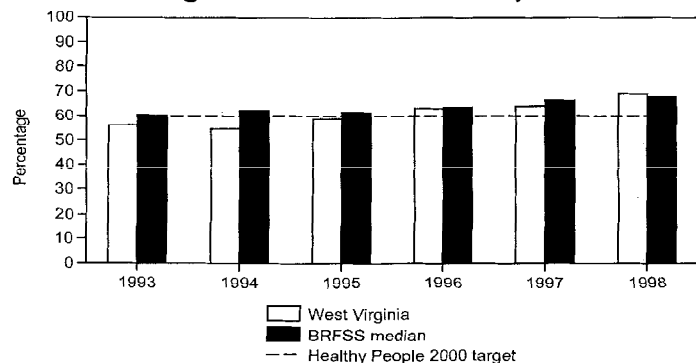
Women’s Health - Cancer Screening

While WV has seen a decrease in the number of deaths attributed to breast cancer, other cancer related deaths continue. The Breast and Cervical Cancer Screening Program, funded by CDC, has enabled WV to establish a formal cancer registry and screening program for identification and intervention services for women between the ages of 50 and 69 years.

**Breast Cancer: Deaths Among Women
West Virginia and United States, 1987-1997**



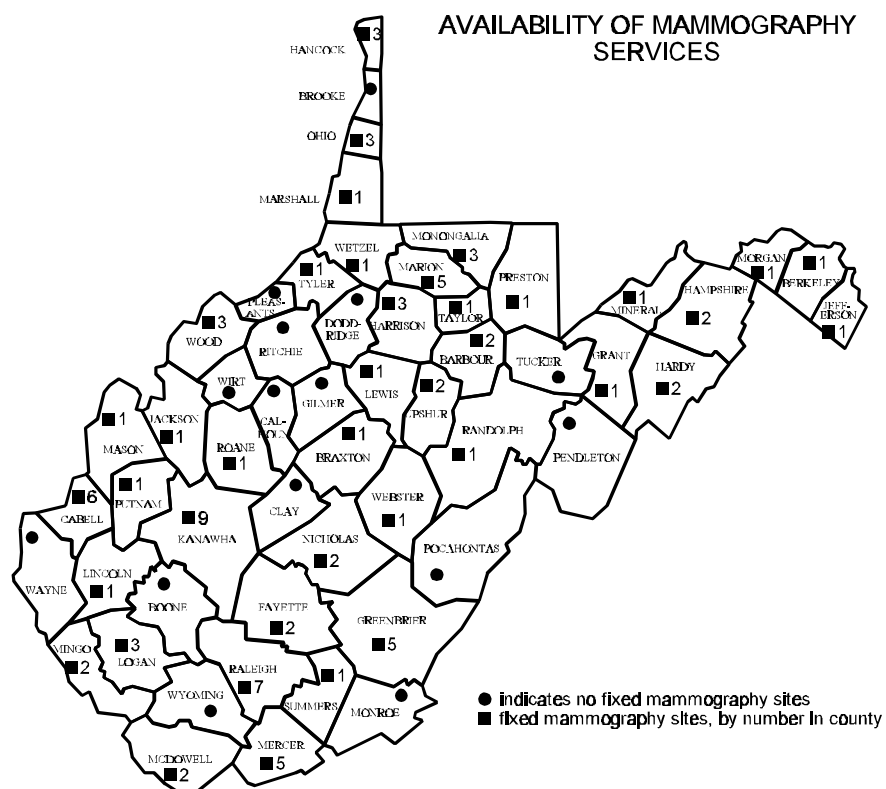
**Women Aged ≥50 Years Who Have Had a Clinical
Breast Exam and a Mammogram Within 2 Years
West Virginia and BRFSS Median, 1993-1998**



Source: Behavioral Risk Factor Surveillance System (BRFSS), CDC.



The program provides leadership, technical assistance and support to community partners who provide the actual hands on care for the targeted population. The program assures the quality of screening procedures for breast cancer and, in the case of mammography, requires American College of Radiology (ACR) accreditation for facilities offering services to program participants. A map portraying ACR accredited, fixed mammography sites is portrayed below.



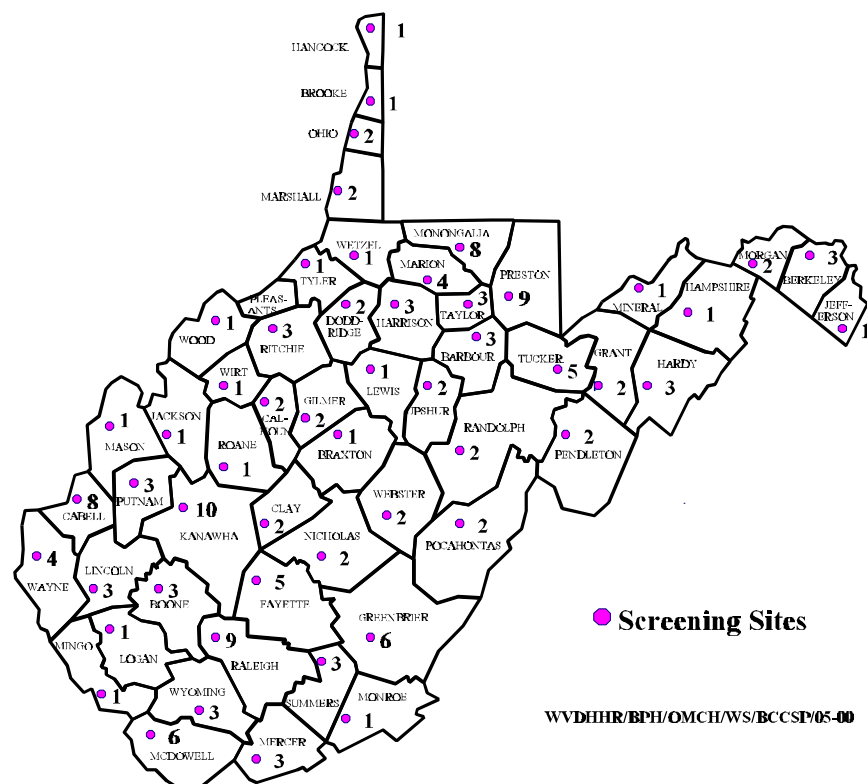
The program also ensures the quality of any screening procedure for cervical cancer and, in the case of the Pap test, requires all specimens be directed to laboratories that are Clinical Laboratory Improvement Amendment of 1988 (CLIA-88) certified. In WV, we have contracted for a CLIA certified, private lab to handle all Pap tests for BCCSP and Family Planning patients.

Partnerships and coalitions are critical to this program. The program partners with the WV Cancer

Coalition to improve community awareness about cancer and the need for and availability of screening services. There is also a medical advisory comprised of physicians, radiologists, etc. who oversee program medical policy.

Priority populations for the program are uninsured or underinsured older women, women with disabilities, and women who live in hard to reach communities. WV has a network of community-based staff, called Cancer Information Specialists who are assigned to work with the media, church, civic organizations, and providers to identify high need/high risk populations. The purpose of public education is to increase the rate of screening in the targeted population, and to ultimately decrease morbidity and mortality from breast and cervical cancer. In addition, professional education is routinely offered by the program which enhances services to all women receiving health care. The purpose of professional education activities is to affect the health care providers' knowledge, attitudes and behaviors, ultimately resulting in more women receiving quality service.

Breast and Cervical Cancer Screening Program Screening Sites



Because of cancer incidence and the success of the program, the state legislature has appropriated monies for treatment of cancers detected by the program. The Diagnostic and Treatment Fund was established in 1996 and provides financial assistance for medically indigent, low income women who are in need of diagnostic or treatment services. Procedures and services covered by the program follow.

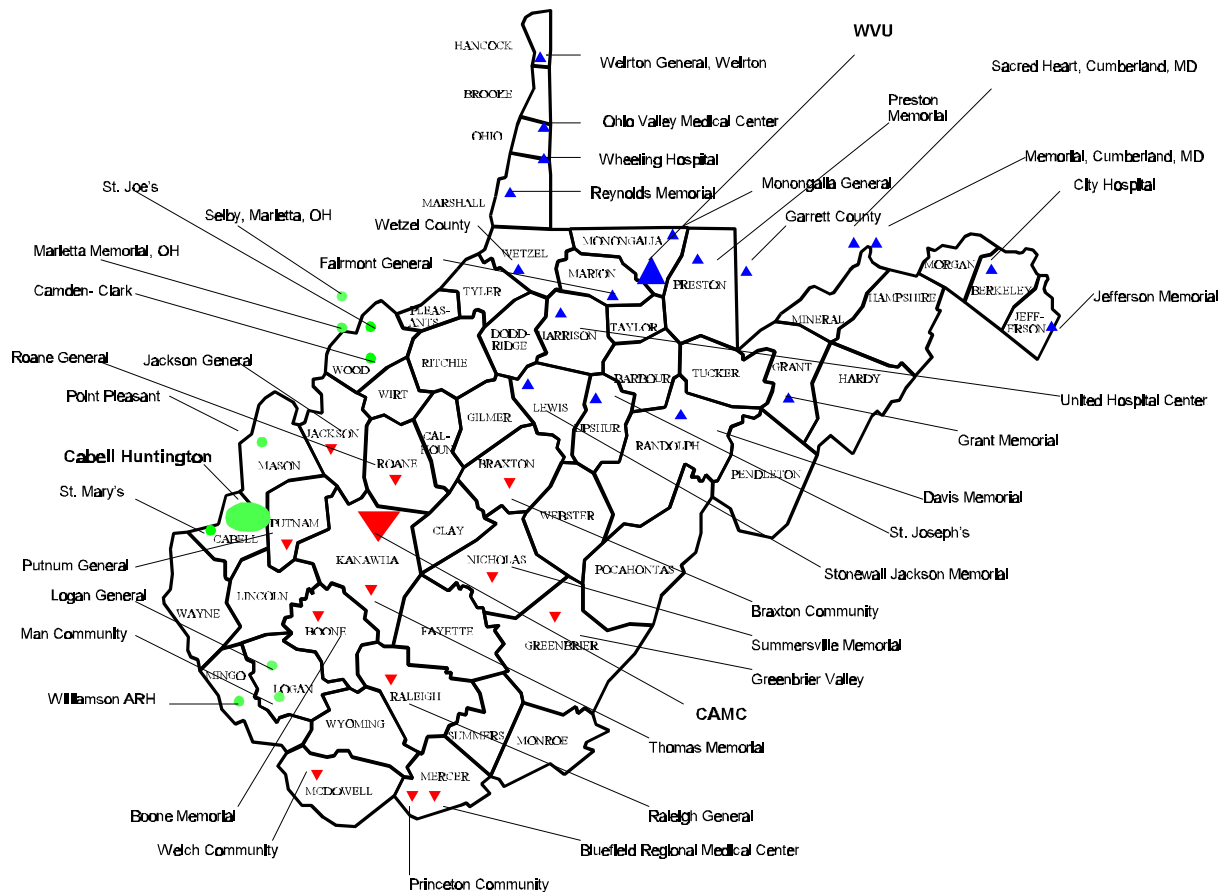
PROCEDURES/SERVICES COVERED BY STATE FUNDED DIAGNOSTIC AND TREATMENT FUND			
BREAST			
Procedure	CPT Code	1999 Rate	2000 Rate
Breast Biopsy - Needle Core	19100	\$82.98	\$106.51
Breast Biopsy - Incisional	19101	\$230.61	\$293.21
Breast Biopsy - Excisional	19120	\$299.71	\$331.99
Breast Biopsy- Radiological Marker	19125	\$318.88	\$362.27
Each Additional Lesion	19126	\$151.43	\$157.31
Pre-Op Placement of Needle Localization Wire	19290	\$94.10	\$123.01
Stereotactic Localization - Breast Biopsy	76095	\$309.89 \$232.81 \$77.08	\$319.22 \$241.26 \$78.66
Needle Localization - Radiological Interpretation	76096	\$69.37 \$42.23 \$27.14	\$71.39 \$43.96 \$27.43
Radiological Examination, Surgical Specimen	76098	\$21.39 \$13.58 \$7.81	\$22.47 \$14.24 \$8.23
Ultrasound Guided Biopsy	76942	\$82.64 \$49.66 \$32.98	\$84.92 \$51.65 \$33.27
Lab-Needle Biopsy	88170	\$76.57 \$16.26 \$60.31	\$79.56 \$15.27 \$64.29
Lab-Surgical Pathology Breast Tissue Biopsy	88305	\$58.72 \$17.23 \$41.49	\$68.45 \$26.82 \$41.63
Stereotactic Biopsy Supplies	A4550	\$26.83	\$19.04
Follow-up After Procedure - Outpatient	99211	\$14.82	\$17.95
Follow-up After Procedure - Outpatient	99212	\$27.52	\$31.36

STATE FUNDED DIAGNOSTIC AND TREATMENT FUND			
BREAST			
Procedure	CPT Code	1999 Rate	2000 Rate
Follow-up After Procedure - Outpatient	99213	\$38.29	\$43.17
Follow-up After Consultation - Post-Op Outpatient	99261	\$25.26	\$24.36
General Anaesthesia	00400	Not Available	Not Available

PROCEDURES/SERVICES COVERED BY STATE FUNDED DIAGNOSTIC AND TREATMENT FUND			
CERVICAL			
Procedure	CPT Code	1999 Rate	2000 Rate
Colposcopy w/LEEP	57460	\$171.07	\$171.69
Endocervical Curettage	57505	\$70.11	\$81.94
Biopsy or Local Excision of Lesion	57500	\$59.38	\$67.74
Cryocautery	57511	\$105.20	\$121.69
Laser Surgery	57513	\$151.14	\$144.49
Cone Biopsy of Cervix	57520	\$268.26	\$273.68
Dilation and Curettage-Diagnostic and/or Therapeutic	58120	\$216.63	\$226.61
Conization w/LEEP	57522	\$242.93	\$242.37
Lab-Cervical Biopsy	88305	\$58.72 \$17.23 \$41.49	\$68.45 \$26.82 \$41.63
Lab-Conization Biopsy	88307	\$104.57 \$25.70 \$78.87	\$138.72 \$56.37 \$82.35
Follow-up After Procedure - Outpatient	99211	\$14.82	\$17.95
General Anaesthesia	00400	Not Available	Not Available

3.1.2.5 INFRASTRUCTURE BUILDING

Tertiary care referral for high risk perinatal populations has been supported since the late 1990's by MCH. Although the strategies have changed the commitment to early identification of high risk pregnant women and infants has remained a priority. All thirty-four of the state's birthing facilities receive training and technical support from tertiary care-based teams, called Perinatal Outreach Projects. Team assignments are indicated on the map below:



These teams provide instructions to medical providers in the community on such subjects as early detection of pre-term labor, identification of high risk pregnant women, infant stabilization for transport, etc. Agreements with the state's three (3) tertiary care facilities for these teams are referenced in Section 5.3.

Maternal and Child Health has longstanding working agreements with Medicaid. And while the two units do not always agree on every issue, we have succeeded in increasing access to prenatal care for Medicaid women. We jointly finance early intervention (Part C) for our youngest child populations, and MCH administers the federally mandated EPSDT program.

The Bureau for Medical Services (Medicaid) and Bureau for Public Health, Office of Maternal and Child Health, are housed within the same organizational structure, reporting to the same Department of Health and Human Resources Secretary, see the organization chart, contained in Section 1.5.1 of the Block Grant.

A copy of the Memorandum of Understanding between the Bureau for Medical Services-Bureau for Public Health/Office of Maternal and Child Health appears in Section 5.3.

As portrayed earlier, MCH has forged new partnerships with the Bureau for Children and Families by developing and administering the Pre-Employment Services Project and administering child care funds dedicated to building capacity and capability in the service community. These partnerships have resulted in an economic infusion for community providers, but more importantly, contribute to the improved health and well-being of West Virginia's people.

TANF resources are supporting the Pre-Employment Project and media events around adolescent pregnancy prevention. Child Care Development Block Grant resources are supporting the WV collaborative for training and education called the WV Early Childhood Training Calendar - Resources and the Early Childhood Resource Lending Library. These efforts involve child care, Part C-Birth to Three, administered by OMCH, pre-school special education and Headstart.

WV has at least 10,000 people providing services to young children and their families through various early care and education programs across the state. There are twelve Birth to Three local agency sites employing or contracting for 350 service providers; fifty-five school systems employing at least 500 early childhood personnel, twenty-four Headstart agencies employing 500 individuals, over 350 licensed child care centers employing over 3,500 personnel, and an estimated 4,600 registered family child care providers. **Of the early childhood personnel in the State, over 80% are involved in child care activities.**

The intent of the child care collaboration is to share training resources in order to maximize cost benefit. The project began in 1994 with Operation Tadpole training, which targets early childhood transitioning and expanded to the training calendar, which exists to this day.

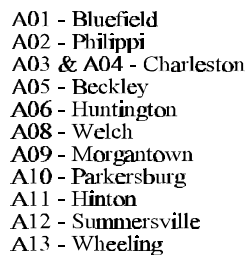
A copy of the Interagency Agreement supporting early childhood initiatives is contained in 5.3. A copy of the most recent Early Childhood Training Calendar is contained there as well.

Traditionally the population of children with special health care needs has been composed of children with physical disabilities that limit ability to function. We have come to realize that the ability of children to function is also limited by chronic or recurring systemic illness not necessarily resulting in a physical disability. The population of special needs children receiving recognition are those that include health-related developmental, learning, and behavior problems. So while WV has made progress in caring for children with disabilities and chronic illnesses, we have fared less well in obtaining (professional) medical support for serving children with "new morbidity" kinds of problems.

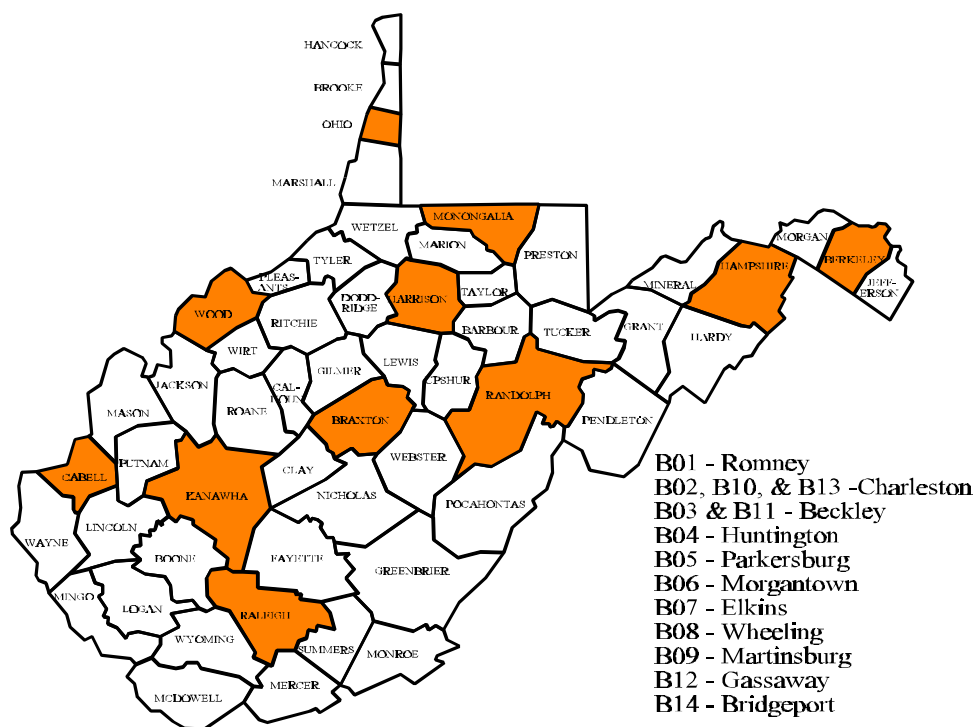
The OMCH and the Office of Community and Rural Health Services (OCRHS) have a longstanding intra-agency agreement to: a) improve health care access; b) promote primary, preventive health care; c) offer technical assistance; and d) share data. This agreement is an affirmation of the state's commitment to working in partnership to meet the needs of maternal and child health populations.

Because tertiary care is often distant from the child's home community, WV has traveling medical teams who offer the services locally. These teams are comprised of private sector physicians and/or the tertiary care medical center staff. Families may intermittently be required to travel to the tertiary care center for follow-up or treatment. In recognition of the hardship this places on families, the DHHR/OMCH bears

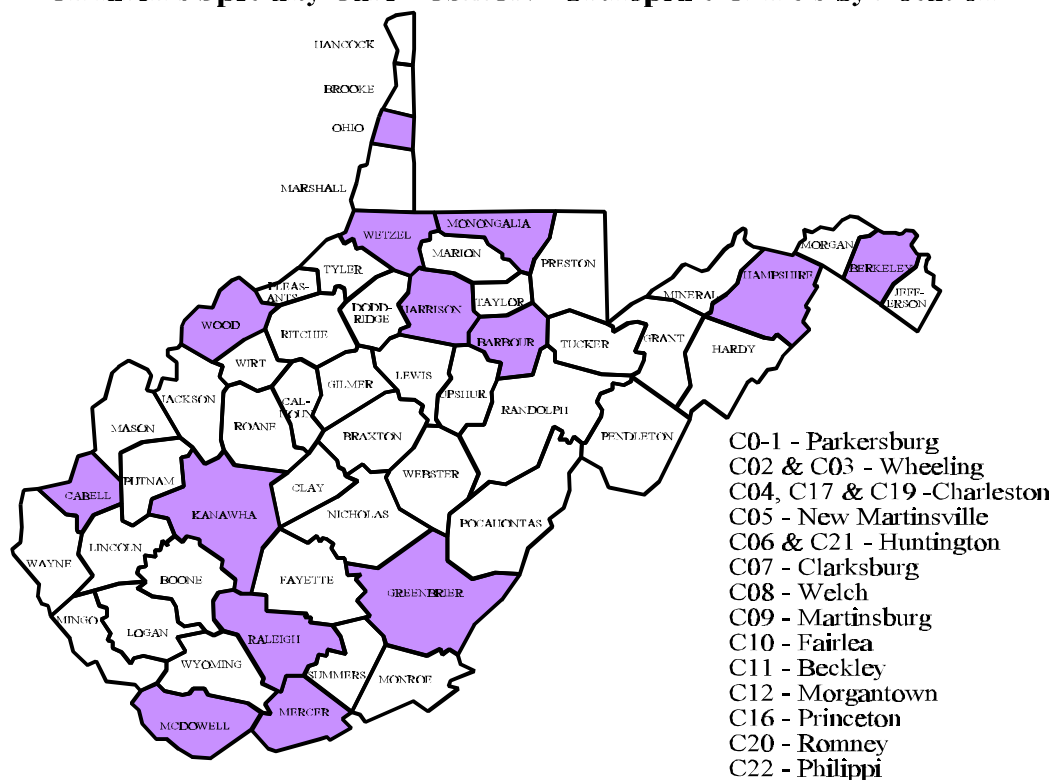
the cost of transportation for the child/family and offers specialty clinics throughout the state.



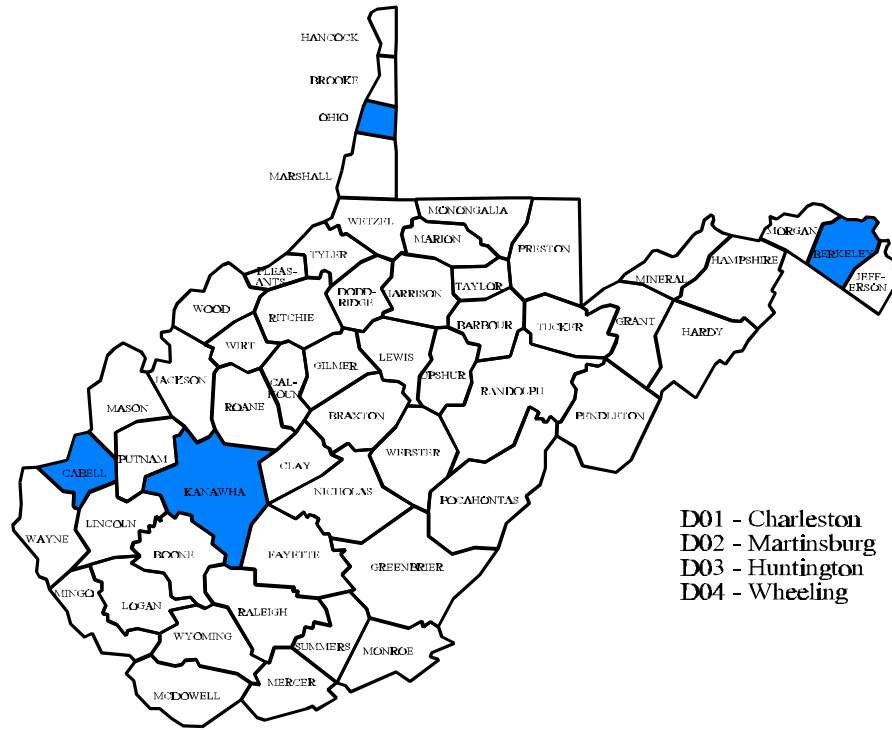
Children's Specialty Care - CSHCN - Neurological Clinics by Location



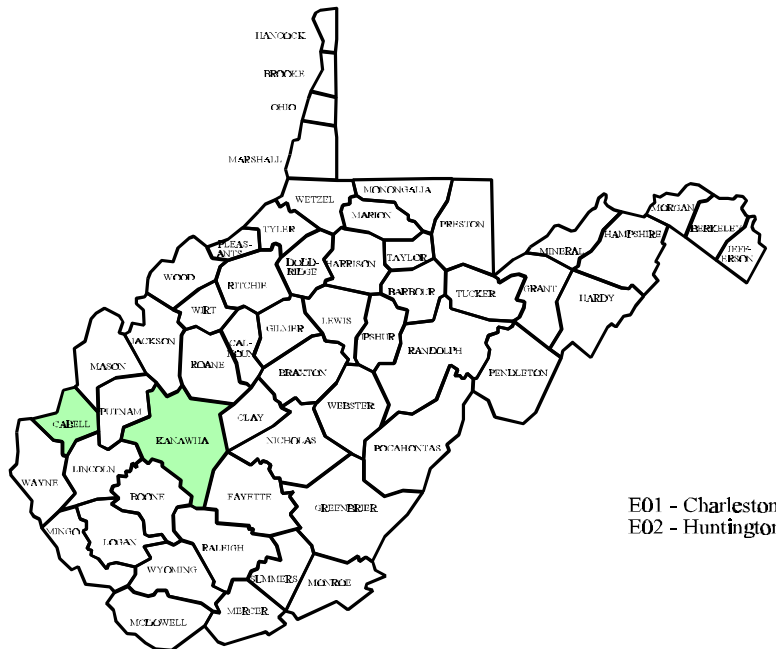
Children's Specialty Care - CSHCN - Orthopedic Clinicians by Location



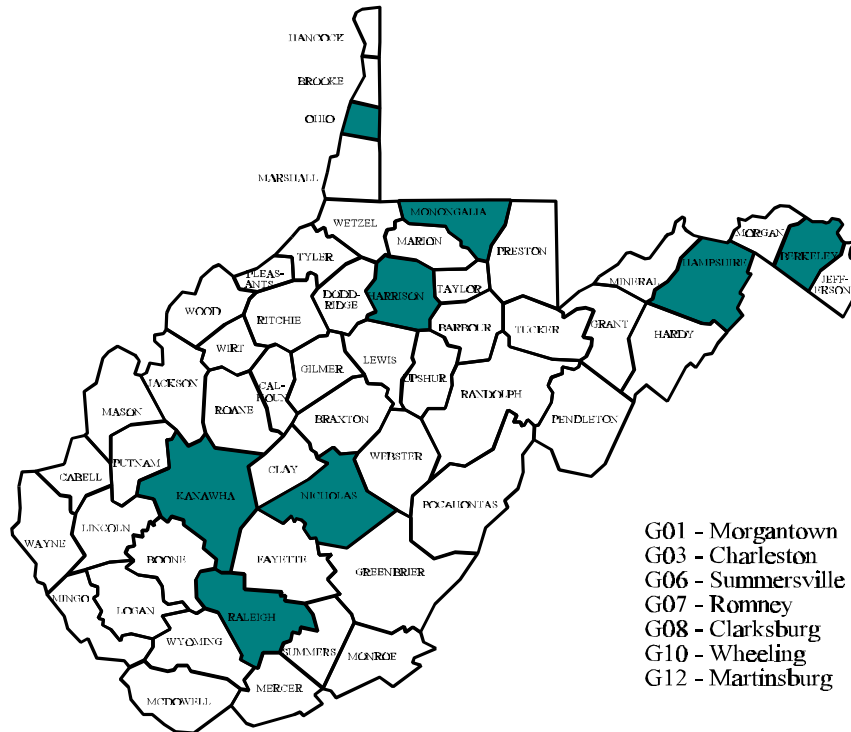
Children's Specialty Care - CSHCN - Plastics Clinics by Location



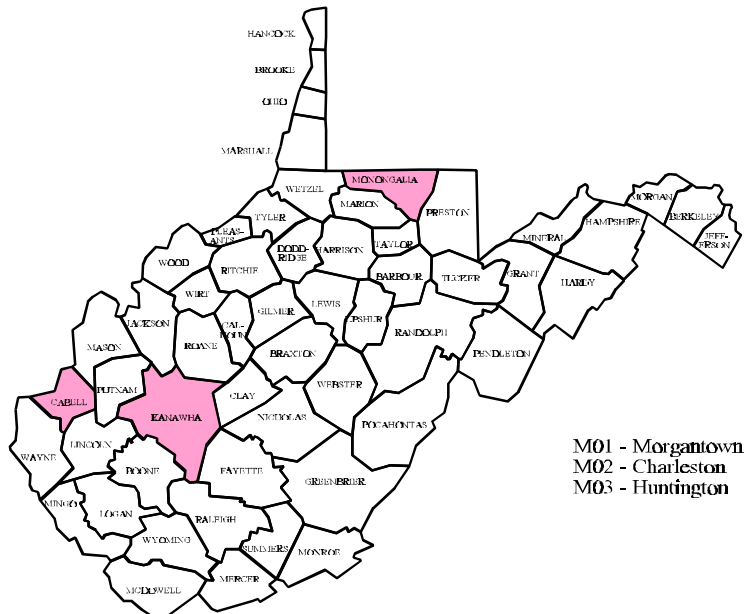
Children's Specialty Care - CSHCN - Cystic Fibrosis Clinics by Location



Children's Specialty Care - CSHCN - ENT Clinics by Location



Children's Specialty Care - CSHCN - Myelo Clinics by Location



Community-based care, coordinated with the primary care (community) providers, is routinely provided. Our biggest challenge is that not every WV county has pediatricians, but we have found that family practice physicians are willing to serve in this capacity if there is a commitment to coordination, consultation, and collaboration by the specialty care practitioners.

Family centered care is built upon collaboration. In family centered service delivery, families are involved at all levels of care – at the level of care of the individual child, at the program level, and at the policy level. Collaboration between families and professionals is the foundation on which many of these roles are built.

Families play a pivotal role in the lives of their children. Because they are the only ones who see their children over time in different settings, parents are finely tuned to their child's needs, as well as their responses to the care given them. As the primary providers of their children's care, parents are the repository of key information about their children. The information they have to offer about their child is often essential to that child's care. Listening to families and providing an array of opportunities for families to share this information is an important role for professionals.

Sharing information with parents helps them to make better decisions. OMCH-Children's Specialty Care, as a part of the assessment process, provides the family with information about their child's diagnosis and treatment alternatives and offers access to medical charts and records, and to the family resource libraries, and family support resources in the community as essential pieces of information necessary to make decisions.

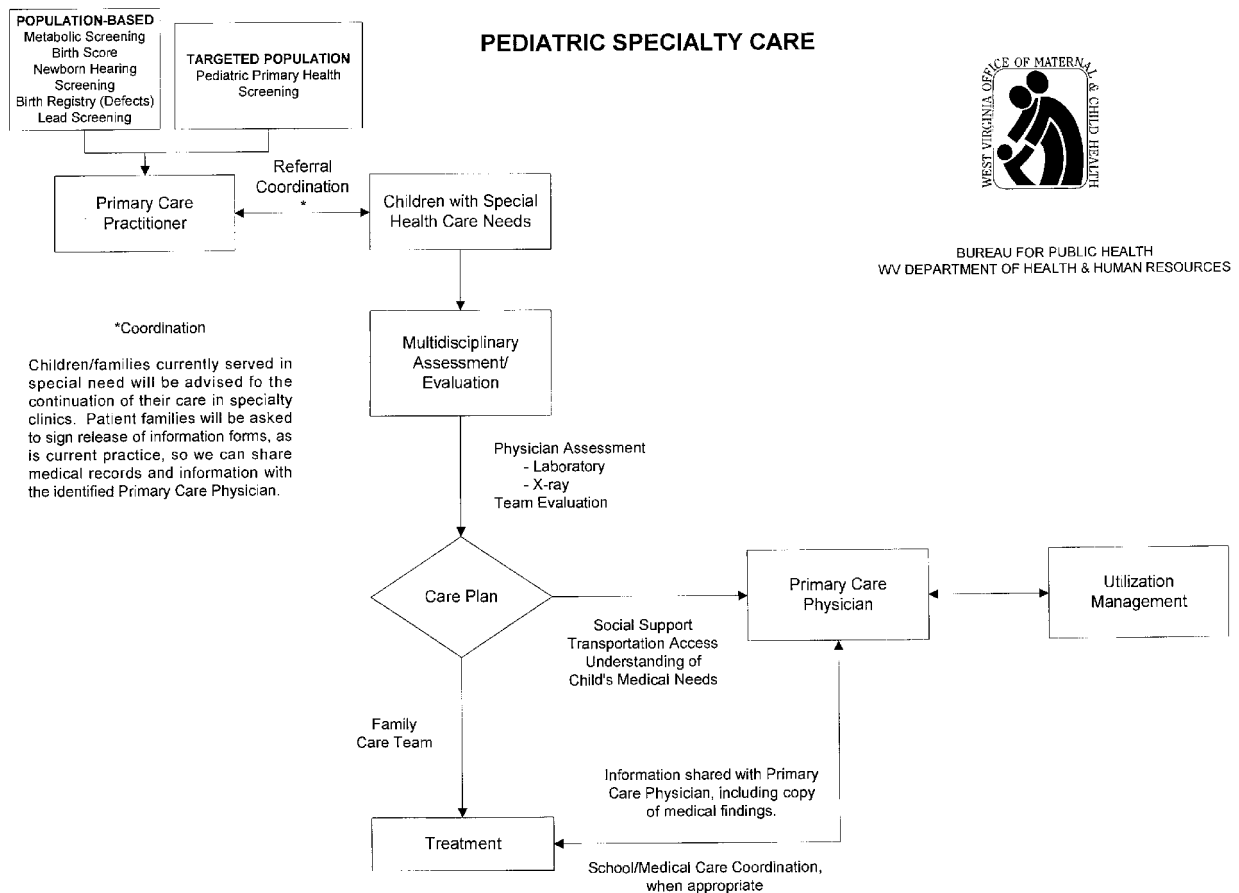
The Children's Specialty Care Division, which houses all children with special need programming, has developed a comprehensive approach to ensure the involvement of families as consultants and advisors.

- The OMCH established a family/professional CSHCN Advisory Committee to advise the Department and act as a resource.
- The OMCH provides fiscal resources to support the Family Resource Library in Morgantown at the University Affiliated Center for Developmental Disabilities (UAP), and administers a similar unit at the state capitol.
- Fiscal resources are provided the UAP to hire parent advisors who participate in the CSHCN clinical network, serve on policy committees, offer in-service training, assist with Title V Block Grant preparation, etc.

- Part C resources also support “Parents as Partners” at the community level, who act as consultants to parents and community-based organizations serving birth to age three populations with developmental disabilities.

- The Medical Education Project at Marshall University enlists parents to participate in training of third year medical students to explore feelings and personal biases that influence diagnosis, treatment, and prognosis of people with disabilities. **Home visits where medical students spend time with families in non-clinical settings are mandatory.** At the end of pediatric rotation, and students re-evaluate their attitudes through discussion of home visiting experiences.

Assessment process for CSHCN portrayed earlier also appears below.



The overarching goal of recent changes in service delivery for children with special needs is the development of an integrated system that will reduce fragmentation, avoid duplication and close gaps in services.

April, 2000



Setting standards for quality care entails the complex movement from identifying abstract values that include goals and expectations, to the formulation of concrete statements that express measurable qualities. The CSC Advisory and the State Interagency Coordinating Council for Part C/IDEA have selected values that focus on the process of health care delivery rather than health outcomes or specific clinical treatment methodologies. These values include the following:

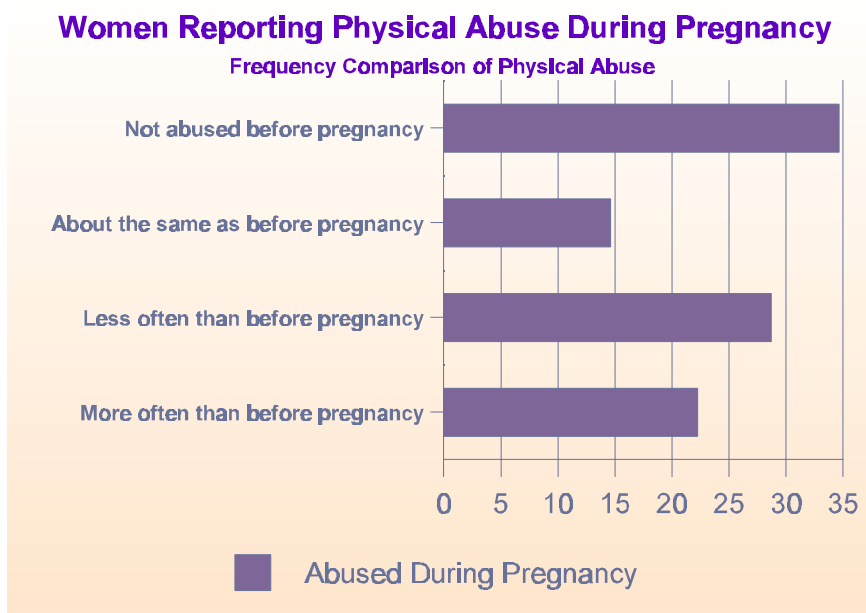
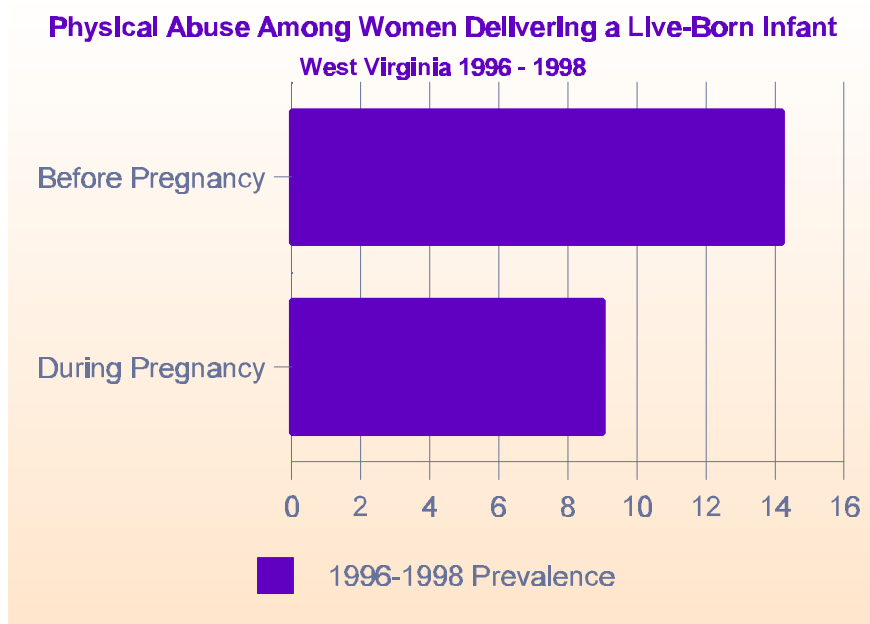
- Rights of families to be involved as partners in the delivery of care and to be recognized as central care givers and decision-makers for the underage child.
- The recognition that children with disabilities or chronic health conditions need a continuum of primary and specialty care and access to community-based non-medical, supportive services.

To provide a larger view of the system's efficacy information from families is routinely obtained through data collection (surveys) and public forums. Survey findings are contained in the Process component of the needs assessment, and actual survey instruments appear as supporting documents.

Advisory committees, comprised of consumers and medical personnel develop medical guidelines for all programs administered by MCH. These guidelines are based on CDC, ACOG, AAP, etc. recommendations for the diagnosis, treatment, and prevention of specific conditions. Every provider of MCH clinical services, EPSDT, Breast and Cervical Cancer Screening Program, Right From The Start, Family Planning, etc. receive a formal agreement which stipulates the scope of services, benefits, method for payment, data reporting expectations, and the standard of practice/quality performance in adherence with nationally recognized practice. The agreement also stipulates that on-site monitoring and record review will occur. This process occurs for private practicing physicians, community health centers, university health facilities, local health departments, etc. without exception.

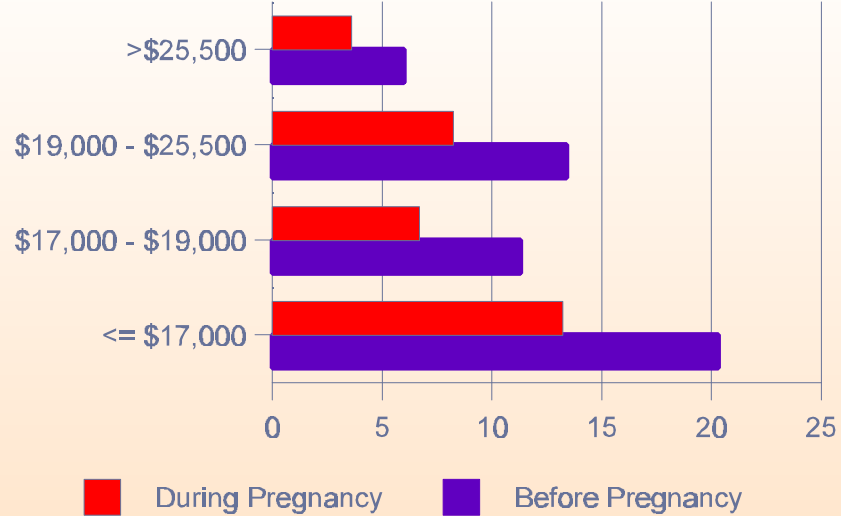
Health Status Surveillance

Monitoring and surveillance are fundamental functions of public health and have become well established tools to support health promotion, disease prevention, and research efforts, in addition to being important to program planning, implementation, evaluation and advocacy. These activities provide the means to ensure that health status is maintained or improved within populations and communities; that emerging health problems are identified early; that necessary health and related services are available, accessible, and of high quality; and that expenditures are justified by documented results. An example of WV research efforts is portrayed in the following study of physical abuse among women delivering a live-born infant. The research is based on PRAMS data gathering.



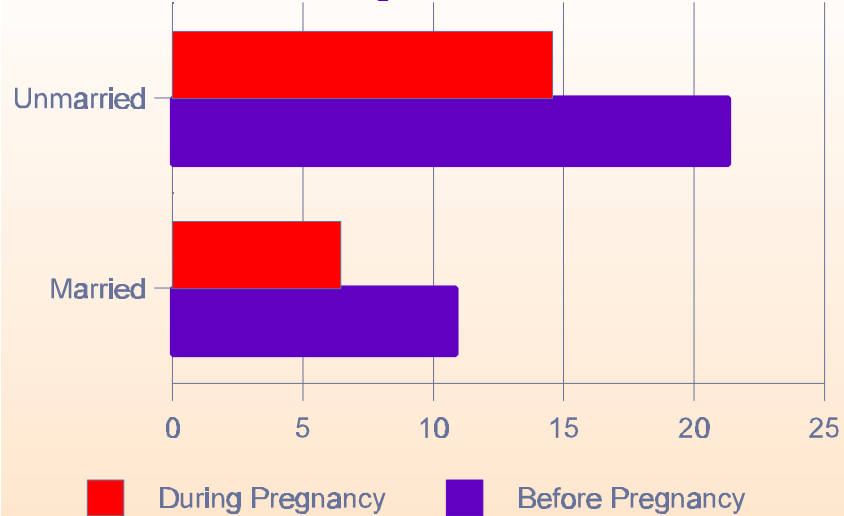
Women Reporting Physical Abuse by Household Income

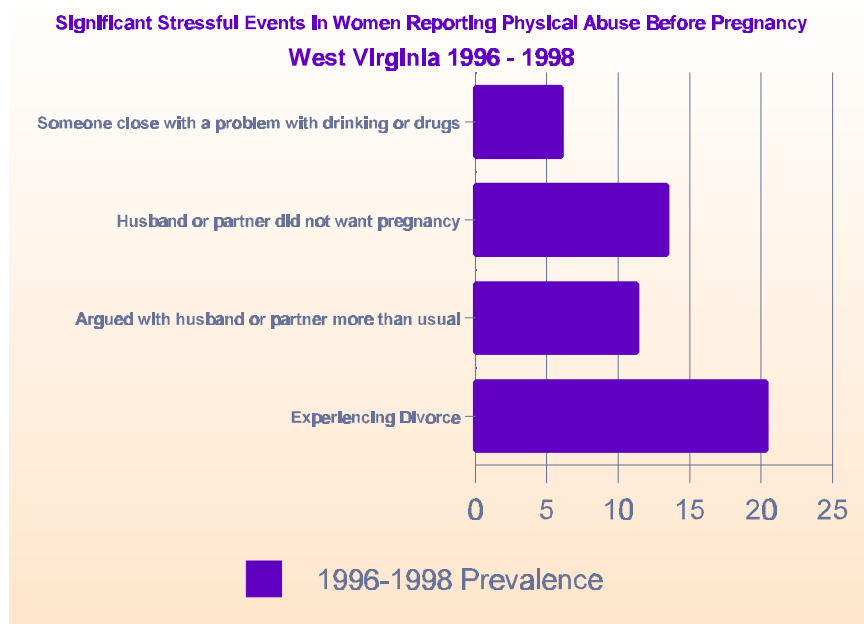
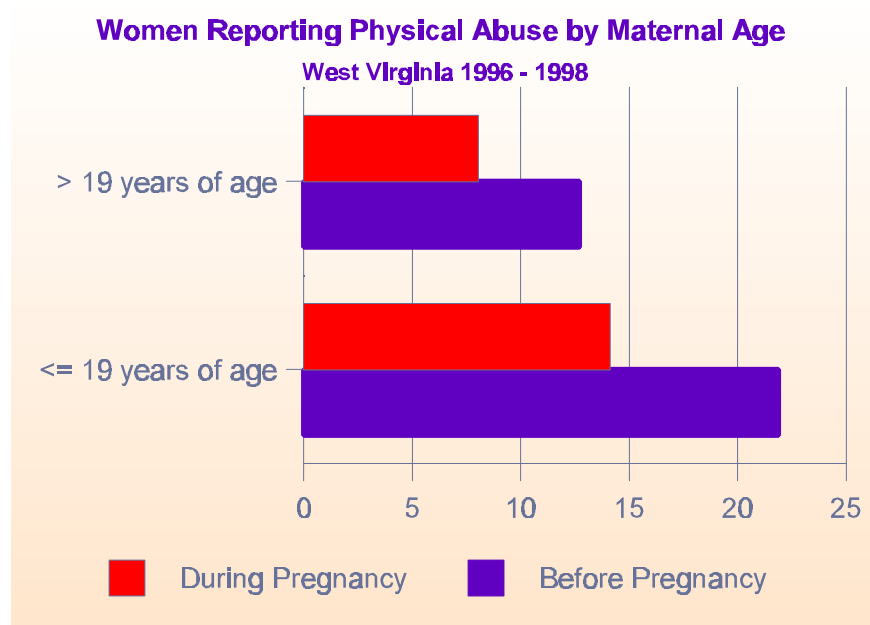
West Virginia 1996 - 1998

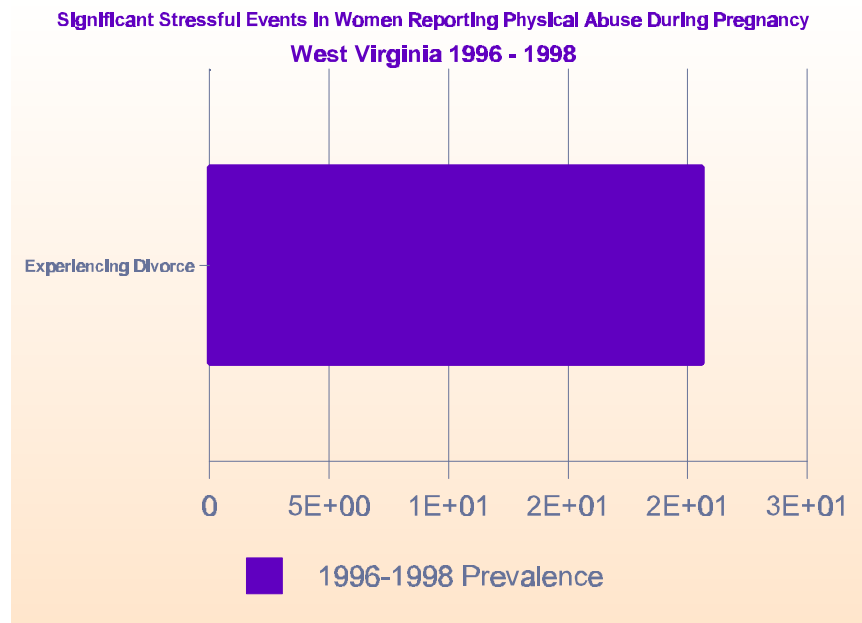


Women Reporting Physical Abuse by Marital Status

West Virginia 1996 - 1998







Detailed information about the availability of health data in West Virginia is portrayed in the appendices. This information documents data source and health status information portrayed. It also reflects other strategies used to prepare the needs assessment, such as specially formed task forces, surveys, public forums, and hearings.

Quality Assurance/Monitoring

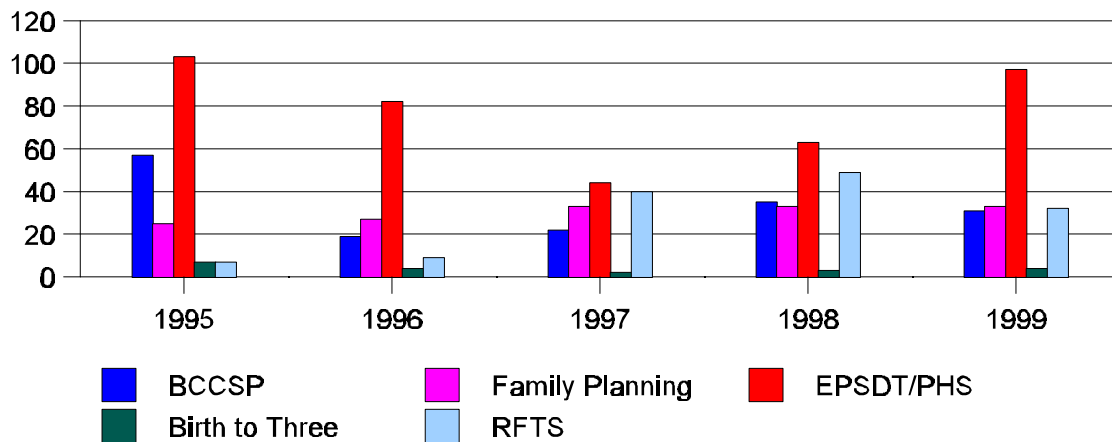
The OMCH Quality Assurance Monitoring Team has over 20 years proven experience in conducting on-site clinical and care coordination monitoring of patient/client medical and care plan records and services. Reviews are designed to objectively and systematically observe, record and verify those services required of all OMCH contracted providers. This information is submitted in report form to the Director of the OMCH program being monitored, the contracted provider delivering the patient/client services, and the Director and/or Associate Director of OMCH. Each program within OMCH reviews their respective monitoring report and develops a “Plan of Correction” with the contracted provider. The Quality Assurance Monitoring Team keeps a copy of all reports and tracks the “Plans of Correction” submitted by the contracted providers. Reports that identify issues within the OMCH management system are addressed by the OMCH Administration. The Quality Assurance Monitoring Team serves as a catalyst for enhancing change and communication by clearly identifying and verifying clinic activities and then bringing the individual OMCH Program and their contracted providers into direct contact for the desired outcomes. A chart of program monitoring for 1995

to 1999 is portrayed below.

Number of Monitorings by Program 1995 - 1999						
Year	BCCSP	FP	EPSDT/PHS	B-3	RFTS	TOTAL
1995	57	25	103	7	7	199
1996	19	27	82	4	9	141
1997	22	33	44	2	40	141
1998	35	33	63	3	49	183
1999	31	33	97	4	32	197
TOTALS	164	151	389	20	137	861

OMCH Program Monitorings

1995 - 1999



A monitoring tool for the Family Planning Program appears in Section 5.3, Appendix S, as an example of WV's process.

SETTING PRIORITIES

The West Virginia Office of Maternal and Child Health, in collaboration with multiple agencies, family groups, and individuals, has determined that there remain several needs across the service system. The needs, as identified, have been linked to Healthy People 2010 Objectives when possible and are listed by targeted populations; i.e., perinatal, children, adolescents, and children with special health care needs.

Families of children with special health care needs require the same sorts of support as do families with children who do not have special needs; that is to say, they require basic health care, education, recreation, socialization, transportation, and other systems to support them in their roles as family members and to help them raise children to be healthy, responsible, competent adults. All families need these systems to be available, accessible, and responsive to their needs.

As a result of multiple surveys and public forums, several overall system needs became apparent. Within the Direct Health and Enabling Services category, West Virginia is severely lacking in respite services. Respite services are almost non-existent, even for high need, targeted population groups like Medley class members who were previously institutional residents. In addition, all focus groups reflected the importance of self-determination needs in the state. The State OMCH received useful documentation that reinforces the priority of this need from the “Let’s Get A Life Project” in their report, contained in 3.1.1.

Within the Population-based Services category, surveys and public forums, the Medley class survey and the Developmental Disabilities Council survey, show that oral health services are cited as the greatest need among adults with disabilities. Also, even when children have health care financed (Medicaid), there is poor utilization of oral health services. Finally, survey results confirm that vocational transition services are in need of renewed support in West Virginia. Approximately 1/3 of survey responders indicated the need for children to receive transition or vocational planning.

Causes of infant death must be addressed, specifics to be developed during a summit of policy makers, medical personnel, etc. in November 2000.

Within the Infrastructure building category, we observed that recruitment and retention of qualified medical and other service delivery personnel in WV must receive priority attention in the future. Projects such as the WV Birth to Three “REIP” program have proven beneficial in recruiting and retaining specialty therapists across the state. (Similar programs could be utilized across the entire OMCH population.) Moreover, insurance systems within the state infrastructure require modification to better accommodate children and families in WV. Recognition of CSC services to include reimbursement for non-traditional services such as intervention by licensed behaviorist and other professionals must become a priority.

The WV Bureau for Public Health has concluded that the following statements constitute the state’s top priority need areas:

Direct and Enabling Services

- Key insurance systems within the state require modification to better accommodate children and families in WV.
- Persons with disabilities have declared the right to self-determination and advocacy as a WV priority. Included in this declaration is the issue of independent living, meaningful employment opportunity, etc.

- Adolescent health service utilization needs to be increased and additional resources dedicated to affecting behavioral changes such as increased use of seatbelts, decreased use of alcohol and tobacco, increase in the number of adolescents abstaining from sexual activity, and decrease in school drop outs.
- The number of women smoking during pregnancy must be decreased.

Population-Based Services

- Quality contraceptive health services must be universal as a means of supporting healthy families and reducing unintended pregnancy.
- All children must have a source of health financing and a health home.
- Oral health services in WV should be improved, and their availability augmented, both for children and adults, especially adults with disabilities. Oral health must be integrated into general health.
- Attention must be given to causes of infant death in WV – reduce the infant mortality rate.

Infrastructure

- Recruitment and retention of qualified medical and other service delivery personnel in WV must be given increased attention.
- Specialty medical services for children with chronic debilitating conditions are a priority as is the improved availability of obstetrical services.
- An adequate supply of safe and enriching center-based care must be available where acceptable relative care is unavailable with adequate subsidy to allow parents to work.

**Matrix of WV Issues - By Population Category and Priority
Based on Data Reports, Systematic Surveys and Forums**

(Health) Problem	Source of Recommendation/Documentation
Perinatal <ul style="list-style-type: none"> • Infant mortality • Smoking during pregnancy • Low birth weight incidence • Unintended pregnancy/teen pregnancy • Health care access for obstetrical services (availability) 	<ul style="list-style-type: none"> • PRAMS Data • Perinatal Task Force • Vital Statistics • Kids Count/WV Component/The Annie E. Casey Foundation
Child & Adolescent <ul style="list-style-type: none"> • Child poverty • Adolescent pregnancy • Adolescent smoking • Oral health care utilization • Availability of quality child care 	<ul style="list-style-type: none"> • Vital Statistics/BRFSS • Child Health Advisory • Children's Oral Health Advisory • Adolescent Pregnancy Prevention Task Force • Children's Oral Health Assessment (97-98)
Children with Special Health Care Needs <ul style="list-style-type: none"> • Availability of sub-medical specialty care (OT, PT, Speech) • Right to self-determination • Access/architectural barriers • Transition to adulthood <ul style="list-style-type: none"> • Employment opportunity 	<ul style="list-style-type: none"> • CSC Advisory • Let's Get a Life Project • Parent Empowerment Network • Birth to Three Evaluation and Forums • Developmental Disabilities Council Forums and Surveys

3.2 Health Status Indicators

3.2.1 Priority Needs

See Form 14.

- To reduce the proportion of women smoking during pregnancy.
- To reduce the proportion of unintended pregnancies.
- To increase the proportion of women receiving first trimester prenatal care whose prenatal care is paid for by Medicaid.
- To increase the proportion of women ≥ 18 receiving Pap smears within the preceding three years.
- To increase the proportion of eligible children who receive EPSDT services.
- To identify as early as possible all children at risk of chronic or debilitating conditions and arrange for appropriate care.

- To increase the proportion of age appropriate children screened for blood lead.
- To increase the number of children receiving oral health care, with special emphasis on children whose health care is paid for by CHIP and Medicaid.
- To increase the proportion of women ≥ 50 receiving mammograms within the preceding two years.
- To reduce the incidence rate (per 100,000) of females aged 15-19 years diagnosed with Chlamydia.
- The OMCH continues to work cooperatively with the Division of Surveillance and Disease Control, which is responsible for the STD Program. Patients participating in Family Planning are routinely screened for STDs with the following results:
 - Females Attending Family Planning Clinics 1.9%
 - Females Attending STD Clinics 3.5%
 - Males Attending STD Clinics 5.8%

3.3 Annual Budget and Budget Justification

3.3.1 Completion of Budget Forms

See Forms 2, 3, 4 and 5.

3.3.2 Other Requirements

The Title V Agency in West Virginia, the Office of Maternal and Child Health, maintains a funding distribution whereby 30 percent of the funds are dedicated to the State's Children with Special Health Care Needs Program, 30 percent to programs for pregnant women, 30 percent to infants and children, and 10 percent only dedicated to administration.

As the budget forms indicate, there are a number of other MCH-related sources of funds under the administrative control of West Virginia's Title V agency. Through cooperative agreements with the Centers for Disease Control and Prevention, the Office of Maternal and Child Health receives funds for the PRAMS Project, the Childhood Lead Poisoning Prevention Project, and the Breast and Cervical Cancer Screening Program. In addition, the Office of Maternal and Child Health has an SSDI grant and an Abstinence Only Education grant from MCHB. The Bureau for Medical Services in West Virginia contracts with the Office of Maternal and Child Health to administer the State's EPSDT Program and to oversee prenatal care for Medicaid cardholders. Finally, the State's Birth to Three (Early Intervention) Program, funded by the U.S. Department of Education, is administered by the Office of Maternal and Child Health.

The state match for the Maternal and Child Health Block Grant comes from a state legislative appropriation.

3.4 Performance Measures

3.4.1 National “Core” Five Year Performance Measures

3.4.1.1 Five Year Performance Targets

See Form 11.

3.4.2 State Negotiated Five Year Performance Measures

3.4.2.1 Development of State Performance Measures

See Form 16.

3.4.2.2 Discussion of State Performance Measures

See Form 16.

Each state performance measure was selected because of the health status of the respective population. For example, we have worked hard for years to assist Title XIX sponsored patients with early entry into prenatal care; however, we still have not achieved the 90% first trimester enrollment goal of Healthy People 2010. Furthermore, WV women continue to smoke during pregnancy and an extraordinary number of WV children are exposed to second hand smoke.

In an effort to improve population-based surveillance systems, WV pursued CDC funding for lead screening of its children. This money has been used to build capacity at the State Laboratory including the purchase of a graphite furnace. It is our intention to identify children within the first six months of life who have or are at risk of developmental delays, so the addition of lead screening activities only serves to strengthen this population-based surveillance activity.

We also have cervical cancer as one of the leading causes of death of WV women, and the opportunity to offer breast and cervical cancer screening for high risk women who might not otherwise access appropriate medical screening is a part of our effort to improve the quality of life for West Virginians. We also are tracking WV women who have HPV and would subsequently like to have resources to administer a study to see how many of these women develop cancer of the cervix.

If every West Virginian is to have improved health status, we also need to help families plan and space pregnancy. This has continued to be a challenge, and even with more than 128 clinics offering services statewide, we still have unintended pregnancies that ultimately have implications for child well being and family functioning (child abuse and neglect and family violence).

3.4.2.3 Five Year Performance Objectives

See Form 11

3.4.2.4 Review of State Performance Measures

Face-to-face review.

3.4.3 Outcome Measures

See Section 5.11

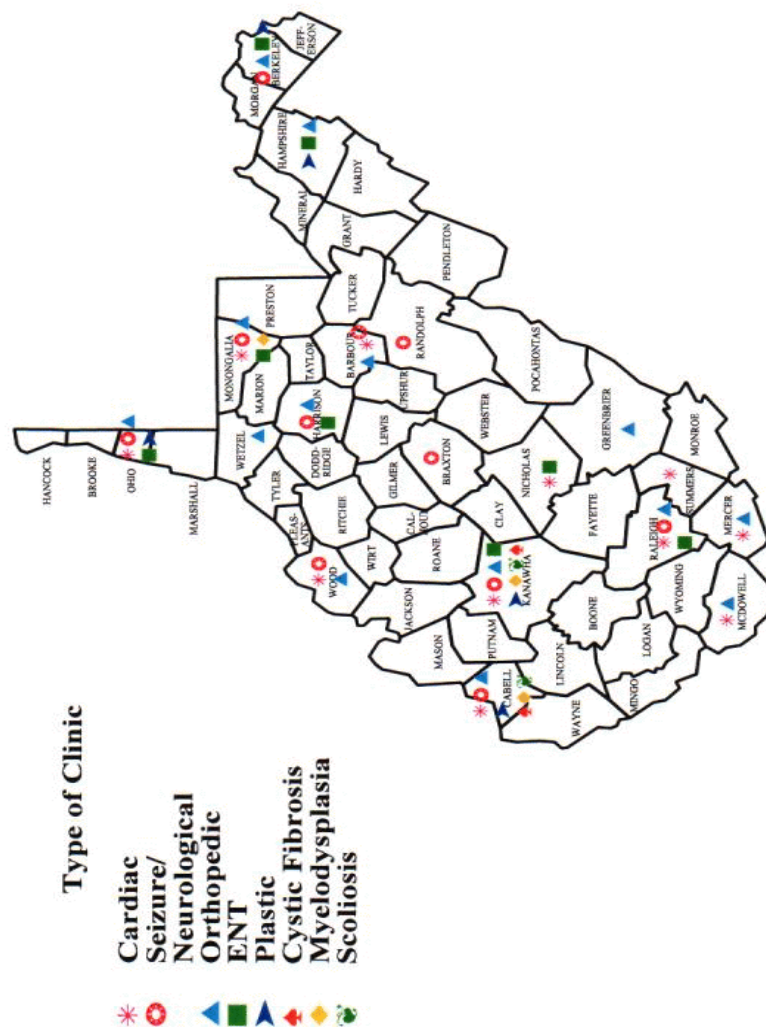
IV REQUIREMENTS FOR THE ANNUAL PLAN

4.1 Program Activities Related to Performance Measures

The Office of Maternal and Child Health, Bureau for Public Health (BPH), Department of Health and Human Resources, is the “single state agency” for Maternal and Child Health in West Virginia. The OMCH plans, promotes and coordinates a statewide system of comprehensive health services for women, infants, children, adolescents, and families of children who have special health care needs. The Office is known for longstanding community partnerships between the public and private sector which has ultimately resulted in improved health status and access for maternal and child health populations.

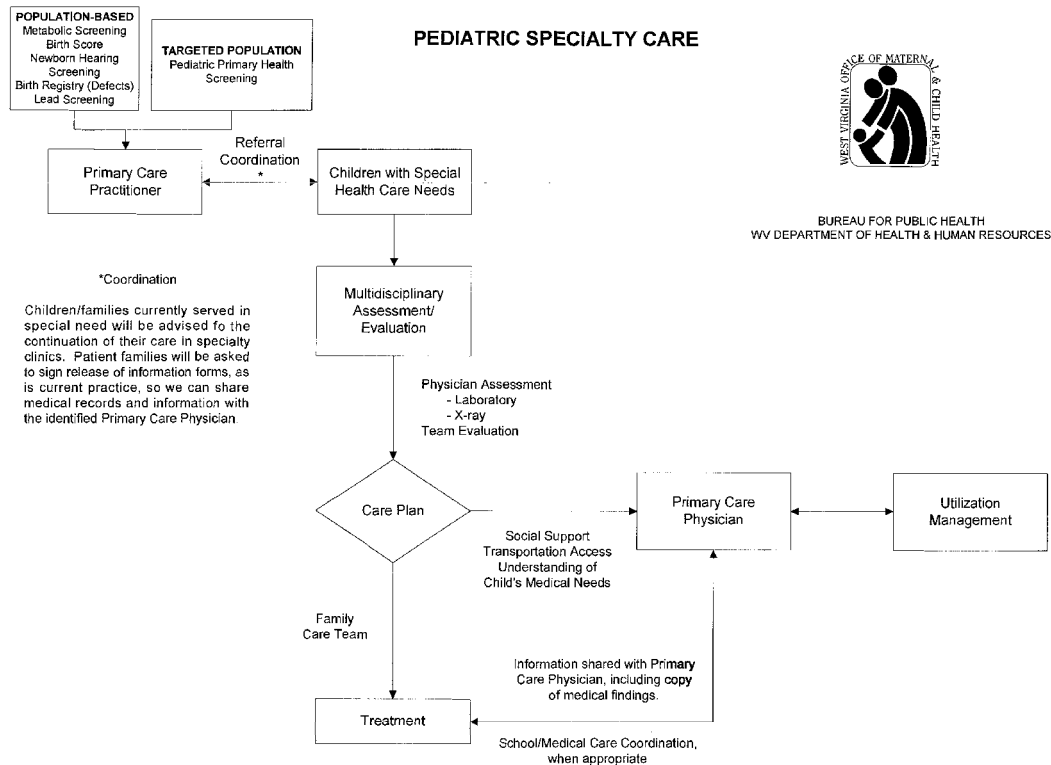
The Office of Maternal and Child Health, since the 1980's, has contracted for the provision of direct health care. These contractual relationships include private sector physicians, university-medical school partners, hospitals, community health centers, and local health departments. All services are formally contracted with established performance standards portrayed in the written provider-OMCH agreement. The exception to this format is CSHCN, which was, until the late 1980's, administered by the former Human Services arm of the now Department of Health and Human Resources organization. This unit has maintained its **direct service** responsibility because of the scarcity of pediatric and pediatric sub-specialty providers in certain geographical areas of the State. See the map on the next page for clinical locations by medical type.

Children with Special Health Care Needs Clinic Locations



WVDHHR/BPH/OMCH/CSC/CSHCN/MAPCOL4/24/00

The program receives referrals from multiple sources. However, as the State has developed and improved **population-based surveillance systems, more and more youngsters have been referred, as a result of the birth defect registry, birth score, and metabolic screening.** It is also important to note that the State's universal risk scoring of infants, called birth score, was modified several years ago to assure the identification of infants with or at risk of developmental delay. These children are referred to the MCH administered Birth to Three Program/Part C IDEA. In addition, MCH administers EPSDT, again with direct care through community provider partnerships, but we do have access to information on each child, enabling us to identify youngsters with chronic or disabling conditions for referral to CSHCN. The primary care physicians are encouraged to refer children to CSHCN, and are routinely visited by Pediatric field staff who serve as technical resources to the medical community. A portrayal of how the system works is depicted in the diagram below. **Cue:** Population-based referral systems used to identify the targeted population were portrayed earlier, section 1.5.2.



All children assessed by CSHCN receive evaluation and case management services to facilitate access to alternative systems of care. All children enrolled in CSHCN, Birth to Three (Part C IDEA), or even our perinatal RFTS program receive care management and care coordination. A further example of **enabling services** provided by the State Title V CSHCN Program is reflected in the following table, with 78.5% of the Children with Special Health Care Needs Program participants accessing Medicaid. This high percentage is attributed to CSHCN commitment to assisting families with SSI applications, the expedited SSA/Disability Determination process, and our attention to obtaining health care financing for this targeted group. The above depicts state enabling efforts contributing to the achievement of national performance measures 11 and 13.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS PROGRAM			
CLINIC UTILIZATION REPORT: 1999			
CATEGORY			TOTAL
Initial Clinic Visits: Assessment/Diagnostic Work-up			917
Patient Clinic Encounters (Number of Patient Visits)			5,690
Total Number of Program Enrollees			4,281
% Served/Medicaid Eligible			78.5%

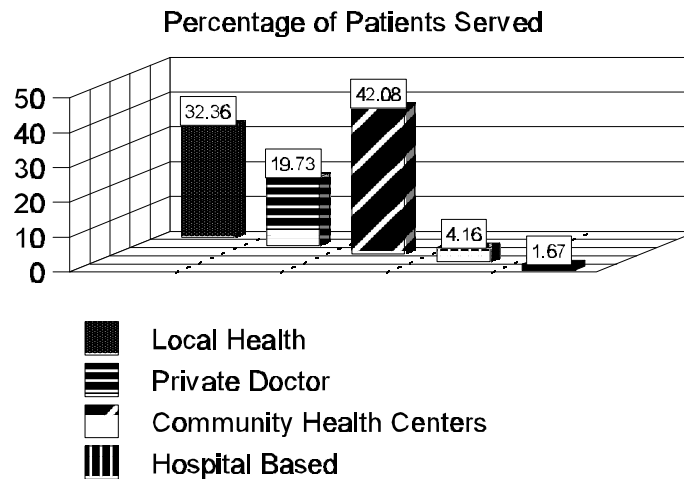
COVERED MEDICAL CONDITIONS			
Cardio-Vascular	Plastic	Ear, Nose, Throat	Musculo-Skeletal
Neuro-Muscular	Digestive	Ophthalmology	Genetics
Hematologic Disorders	Metabolic	Pulmonary	Genito/Urinary
Dental (Cleft Lip and Palate and other severe craniofacial anomalies).			

The Office supports the Birth Score Project and Genetics Program administered by WVU, Department of Pediatrics. The support for these programs are at the heart of building capacity for the system of care by providing preconceptual counseling; assessment and support for persons with congenital anomalies' and operating a **population-wide surveillance** system designed to identify infants at possible risk of post-neonatal death (birth score, which includes newborn hearing screening).

Primary preventive health care for the State's children has been historically administered by MCH through provider contracts for EPSDT and/or the companion program called Pediatric Health Services (PHS). Pediatric Health Services has continued to pick up the cost of care for children who have not accessed Medicaid or CHIP. It is our intention for this program to be discontinued as CHIP enrollments become more

stable. The PHS has done an excellent job of **gap filling**, and yearly provided payment for 35,000 or more child health visits, and all treatment medications at no cost to the family. Community partners are the recipients of MCH resources as depicted in the chart below.

OMCH Provider Types



Legend: Family Planning Special Agreements - College Infirmarys, Health Rights, etc.
Community Health Centers include Behavioral Health sites.

Originally, family planning services were provided by local health departments, a practice initiated in the late '60's when the program was in its infancy. The program is well received by patients and providers alike, however, with changes in the funding of local health departments and government efforts to assist local health departments transition to core functions, fewer health departments are providing direct care. For example, in the area of pediatric care, WV's local health departments serve less than 17% of the targeted population, whereas community health centers and private sector physicians are most active in the provision of services. We believe that county health departments have continued to offer family planning services out of program loyalty and support for the patients; however, we are seeing a trend, with local health departments discontinuing program participation. Our Title X, Family Planning Program Director, has already started to engage private sector physicians in the program to ensure that the contraceptive needs of persons of childbearing age are met.

State Climate Affecting Annual Targets

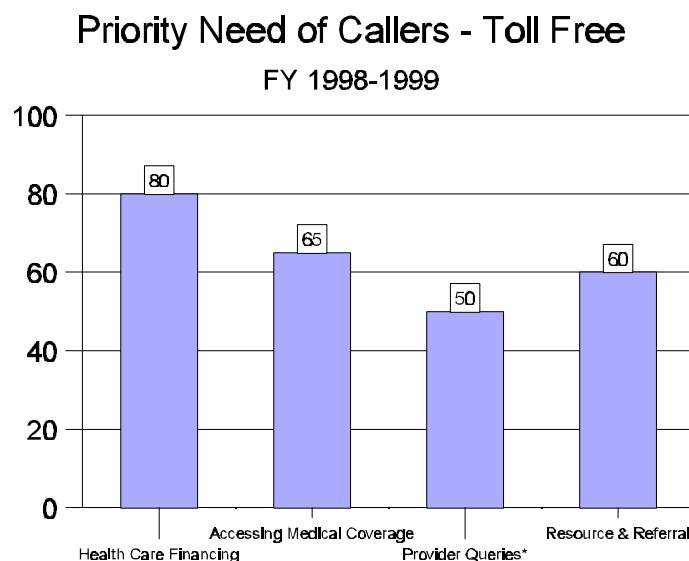
West Virginia Title V, like other states, is being affected by Medicaid growth...with many of our gap filling responsibilities shrinking. Even before CHIP, the Nation saw 5 million newly eligible children enrolled

in Medicaid, and during the same period (1989-1993) West Virginia's Medicaid enrollment increased by almost 15,000 children. **We have also seen an EPSDT eligible population growth of almost 25% in FY 99, which we believe is attributable to outreach for CHIP and subsequent identification and enrollment of Medicaid eligible children into the system.** The simultaneous growth in Medicaid and managed care affects MCH. At this point, West Virginia Medicaid has not enrolled SSI populations into Medicaid Managed Care, but when they do, our ability to administer the CSHCN Program may be jeopardized. The OMCH has received support for advocacy attempts to keep the CSHCN Program from being included in MMC...this is still an on-going interdepartmental debate. MCH partners, including the UAP, the Development Disabilities Planning Council, Family Voices are not in favor of children with special needs being assimilated into Medicaid Managed Care.

On a brighter note, we believe that many of the State's systems are being strengthened, in part because of state legislative support. A good example was the passage of newborn hearing screening legislation in 1998, and the codification of the birth score system.

4.2 Other Program Activities

The OMCH continues to provide monies for maintenance of a data repository which keeps current health, social, and community information by county and by type of service statewide. This data repository, linked to MCH via modem, is used to access information for client specific questions, received on the MCH toll-free lines. As previously discussed, MCH has well used toll-free lines which are monitored by independent reviewers. All calls, unless client refuses, are followed up by letter. We also maintain resource information on a variety of topics enabling us to respond to specific concerns such as "my child is bed wetting," "I have a breast lump," "I've missed my period," and "Johnny won't eat" (addresses National Performance Measure 18).



Care management and care coordination is provided through established systems, with program specific protocols for each targeted population. In RFTS, social workers and nurses involve parents in discussion of family planning, and assist clients who are economically disadvantaged in accessing health care. Our cadre of community-based family outreach workers (FOW's) encourage families to participate in preventive, primary health care for their children (addresses National Performance Measure 13).

The Adolescent Health Coordinators, located in each of the State's eight public health regions, work alongside West Virginia Healthy Schools Program (funded by CDC) to provide adolescent health education and health promotion programs, as a part of the school health education curriculum. The Adolescent Health Coordinators (AHC) also work with the community to address needs of adolescents identified by youth serving organizations such as churches and civic groups (Boy Scouts/Girl Scouts, Christian Athletes, etc.). The concept of supporting and promoting the health of children in home and community fits well into this initiative.

The availability of a staff person dedicated to pregnancy prevention efforts in the State is a boon to adolescent health programs. We anticipate that preventive services will be offered in the community administered abstinence only programs, that the Adolescent Health Coordinators will offer programs that affect child-family communication, and that the pregnancy prevention specialist will have programs available for youths who are sexually active. More detail is contained in the earlier Perinatal and Women's Health component of this report. This three-pronged approach to adolescent health, which exceeds the scope of reproductive health, will address State Performance Measure 5, unintendedness of pregnancy, and affect the State's infant mortality, if young persons postpone onset of sexual activity.

Coordination with the Social Security Administration - State Disability Determination unit, etc. is portrayed in 3.1.2.2. The toll-free lines are discussed in the needs assessment under Single Point of Entry.

The statewide MCH toll-free line has been in place since 1980. Toll-free responders include nurses and licensed social workers. A portrayal of calls by service need is depicted below.

4.3 Public Input

The Title V Block Grant and the Abstinence Education Application were distributed for public comment as follows:

1. Newspaper ads were run in all papers, announcing the availability of the above documents in draft format at the local Department of Health and Human Resources office located in each county seat and at the public library.
2. Five public meetings were held in late June to secure public input.

- Parkersburg
- Martinsburg
- Fairmont
- Beckley
- Charleston

3. Copies of the draft, including a public comment form, were also sent to the following:
- a. Developmental Disabilities Council
 - b. WVU Affiliated Center for Developmental Disabilities (UAP)
 - c. Social Services (Responsible for IV-B/IV-E, etc.)
 - d. Office of Behavioral Health Services
 - e. Medical Advisory Chairs
 - Department of OB/Gyn - WVU
 - Department of Pediatrics - Marshall University and WVU
 - Department of Community Medicine - WVU
 - f. The Governor's Cabinet on Children and Families
 - g. WV Chapter March of Dimes
 - h. Family Voices - West Virginia
 - i. Interagency Coordinating Council Chair (Part C/IDEA)
 - j. West Virginia Commission for Deaf and Hard of Hearing
 - k. West Virginia Department of Education
 - Office of Healthy Schools
 - Special Education
 - The WV Perinatal Task Force

4.4 Technical Assistance

See Form 15

V SUPPORTING DOCUMENTS

5.1 Glossary

Access to Rural Transportation (ART) - Special project designed by MCH and the Office of Family Support which is responsible for Non-Emergency Transportation Services (NEMT) which provides monies to defray the cost of travel for obtaining medical care.

Adolescent Health Coordinators - Individuals hired through community partnership agreements with responsibility for coalition development, and training programs designed to affect positive parenting, risk reduction behaviors among adolescents, etc.

(High) Birth Score - a codified, uniform process for identifying infants at time of birth who are at risk of post-neonatal mortality. Infants determined to be "high risk" receive an accelerated number of pediatric visits in the first six weeks of life and special supports provided by perinatal services, RFTS.

Birth to Three - The program responsible for services to WV toddlers and their families to qualify for program participation. The toddler must have or be at risk of developmental delay. The program is financed by the

U.S. Department of Education, as a part of IDEA, state appropriation, Title V and Medicaid (Title XIX).

Care Coordination Services are services that promote the effective and efficient utilization of resources within the community for children with disabilities and their families and perinatal populations.

Children with Special Health Care Needs Program (CSHCN) - child population birth to age 21 who have chronic or otherwise disabling conditions that pose a threat to their health and well-being. Eligibility for the program includes income at or below 185% FPL and a program covered diagnosis. Detail of service coverage is portrayed in the grant, along with maps of clinical availability.

Children's Reportable Disease - This unit is housed within the Division of Research, Evaluation and Planning within OMCH and is responsible for lead poisoning prevention, SIDS, metabolic disorders, etc. The unit has programmatic as well as tracking and surveillance responsibilities.

Children's Specialty Care (CSC) - The Division within OMCH responsible for services to families/children with special health care needs. The unit is responsible for program planning and design, and is comprised of Part C/IDEA, called Birth to Three; Single Point of Entry; and Children with Special Health Care Needs clinical services and a network of Parent Advisors.

DHHR - The Department of Health and Human Resources, the administrative umbrella in WV responsible for Medicaid, Public Health, including OMCH, public assistance, Social Services, etc. An ongoing chart is contained in the block grant introduction.

Enabling Services - Referenced under RFTS as a perinatal service and include skill building and risk reduction education efforts offered perinatal populations, and children, including those with special needs.

Fairshake Network - Coalition of persons with disabilities, their families, and other interested parties who advocate for system change, track state and federal legislation, and provide advocacy skill building opportunities for persons with disabilities so they can do self-advocacy.

Family Outreach Workers (FOW) - Paraprofessional workforce hired from the community that they serve to provide outreach to Medicaid populations.

Medley Clan Member - Targeted group of individuals previously residing in mental institutions but currently supported in individualized natural environments; i.e., homes.

Right From The Start (RFTS) - West Virginia's perinatal health program which is responsible for early identification and care coordination to pregnant women and their newborns. Program is administered statewide by community-based regional lead agencies who are responsible for a workforce of 233+ licensed nurses and social workers providing direct services to the population.

Parent Advisor Network - A network of contractual/hired parent consultants assigned by regions to serve in the development of policy, advocacy, etc.

Pediatric Program Specialist - Individual assigned to each region of the state responsible for direct interface with the medical community representing MCH, especially EPSDT. These individuals are college educated and

provide technical assistance to the practicing medical community as it relates to compliance with EPSDT.

Pre-Employment Project - This project, funded by Temporary Assistance for Needy Families arranges for vision and dental services to TANF recipients who, as a part of their case planning, are moving from Welfare to work.

Provider Recruitment - The unit responsible within MCH for engaging dentists and optometrists, obstetricians, doctors, etc. in the provision of services to MCH populations.

Quality Assurance Monitoring - The monitoring team currently comprised by eight persons, all college educated, who provide record reviews and on-site evaluations for all providers of services for MCH populations.

Recruitment for Early Intervention Program (REIP) - Provides stipends or loan repayments in return for a workforce commitment. The project is confined to the recruitment of occupational therapists, physical therapists and speech pathologists.

(Health) Regions - WV is divided into eight regions as portrayed in various maps in the grant. The regional configuration is used for staff assignments, educational-school districts, and local health and human resources offices (DHHR).

WV PRAMS (*Pregnancy Risk Assessment Monitoring System*) which surveys mothers who have recently given birth.

5.2

Assurances and Certifications

5.3

Other Supporting Documents

5.4

Core Health Status Indicator Forms

5.5

Core Health Status Indicator Detail Sheets

5.6

Developmental Health Status Indicator Forms

5.7

Developmental Health Status Indicator Detail Sheets

5.8

All Other Forms

5.9

National “Core” Performance Measure Detail Sheets

5.10

State “Negotiated Performance Measure Detail Sheets

5.11

Outcome Measure Detail Sheets